

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00105					00105				
1. DECEASED-NAME (Type or print) First Middle Last James Vernon Abbott					2a. DATE OF DEATH Month Day Year January 6, 1969			2b. HOUR A.M. or P.M. 9:05 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 27, 1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County, Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY FIRE INS.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 302 Christy Road	
14. FATHER'S NAME First Middle Last CHARLES BARNES ABBOTT					15. MOTHER'S MAIDEN NAME First Middle Last CARRIE RUSSELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) WWII		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS EARL B. WALKER #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD-Cardiomegaly DUE TO, OR AS A CONSEQUENCE OF (c) COPD-pulmonale								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia; Severe pulm. Emphysema years									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. OF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Summer, 1968, to present, 1969, that (I) (we) last saw the deceased alive on 1-5-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter F. Verkouw					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-1969		
22d. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M. D.					22e. ADDRESS 1407 Forest Drive, Annapolis, Maryland				
23a. BURIAL, CREMATION, REMOVED (Specify) BURIAL		23b. DATE JAN 9 1969		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF Cem.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.			
24. FUNERAL DIRECTOR JOHN M. TAYLOR SOWS ANNAPOLIS MD					ADDRESS		25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00106												
Item#5Film#G408 11/22/69 vmp												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Ionia D. Allen						2a. DATE OF DEATH 1 Month 15 Day 69 Year			2b. HOUR 2:55A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6-3-87 82			6. AGE (In years last birthday) 88 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co.						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 114 5th. Ave. S.E.			
14. FATHER'S NAME First Middle Last Robert W. Griffith				15. MOTHER'S MAIDEN NAME First Middle Last Maty E. Donaldson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Elva Bailey, 108 5th Ave. S.E.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Bronchopneumonia 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 1/14 , 19 62 , to 1/15 , 19 69 , that (I) (we) last saw the deceased alive on 1/14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Hilary T. O'Herlihy M.D.						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/15/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 18 Jan. 69		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery				23d. LOCATION (City or Town) (County) (State) Friendship Airport AA, Md.				
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.						25a. RECORDS REGISTRAR JAN 17 1969						

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UNITED STATES OF AMERICA

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Extensive Bookings

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00107				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00107			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
MATTHEW			THOMAS	ALVIN	ANDERSON	January 29 1969			1451 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negroid		January 25, 1888		81 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S. A.				ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
ANNAPOLIS			NAVAL HOSPITAL			Navy			Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt. 5, Box 1		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Matthew			MMN	Anderson		Katie			MMN	Stansbury	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
Yes			1920-1947		230-22-3560		Annapolis, Md. Clara Margaree Anderson -Rt. 5-Box 40				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE											
486X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) PNEUMONITIS AND MULTIPLE LUNG ABSCESSSES											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			NO		
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from 1-17, 1969, to 1-29, 1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
A.C.J. BRICKEL LT MCUSNR										January 30, 1969	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS	
A.C.J. BRICKEL LT MCUSNR										NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			FEBRUARY 3-69		PINE LAWN			Annapolis, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
C.E.HICKS 111 Annapolis, Md.						FEB 5 1969			JUDGE		

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00108		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00108					
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P				
Ida Belle Archer					1 28 69		4:10M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		11 21 1872		96 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Vermont		U.S.A.				Anne Arundel		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Millersville		Knollwood Manor		Housewife		xx					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Queen Annes		Stevensville				19 Bay Side Drive			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Frank				Vassar	Louise				Farland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				018079578-D		L. Blandford		19 Bay Side Dr. Stevensville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral Thrombosis		Arteriosclerotic Heart Disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from April 17, 1968, to Jan 25, 1969, that (I) (we) last saw the deceased alive on Jan 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
Ray M. Smith, M.D.						Jan 26, 1969					
22d. PHYSICIAN'S NAME (Type)		Ray M. Smith, M. D.		22e. ADDRESS		Severna Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		APRIL 69		UNION		MOOSUP CONN.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Edgar L. Lane		CHURCH HILL MD.		28 1969							

00108

STATE OF OHIO

1910

State of Ohio, County of Hamilton, ss. I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court.

Witness my hand and the seal of the Court at Hamilton, Ohio, this 10th day of January, 1910.

Clerk of the Court

Attest: _____
Notary Public for Ohio

RAY M. SMITH, M.D.
JAN 10 1910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00109

00109

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) HEINZ GUNTHER BALTRUSCH			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year JAN 18 1969			2b. HOUR A			
3. SEX Male	4. RACE White	5. DATE OF BIRTH APRIL 9, 1935	6. AGE (In years last birthday) 33 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month JAN Day 18 Year 1969			2d. HOUR A
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? Alien Citizen		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH AACo			Md.
10. CITY OR TOWN OF DEATH Deale, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BRICKLAYER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY AA		13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 46 Mason Beach
14. FATHER'S NAME First WILHELM Middle BALTRUSCH Last LUCY MARIA POHL			15. MOTHER'S MAIDEN NAME First LUCY MARIA POHL Middle POHL Last POHL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 577 66 9047		17. INFORMANT SANDRA BALTRUSCH			ADDRESS Box 46 Deale, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide 9521 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. Linhardt		EXAMINER'S NAME (Type) E. Linhardt		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 1-18-69	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/22/69		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		23d. LOCATION (City or Town) SLITLAND		(County) PG (State) MD	
24. FUNERAL DIRECTOR Hardisty Funeral Home, Gaithersburg, Md				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

P.O. Box 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00110

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles			First Middle Last EDWARD BARTLETT			2a. DATE OF DEATH January 8, 1969			2b. HOUR P 6:15 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 8, 1893			6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel County Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LIFE INS.			12b. KIND OF BUSINESS OR INDUSTRY INSURANCE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1810 Bay Ridge Ave.			
14. FATHER'S NAME First Middle Last EDWARD BARTLETT			15. MOTHER'S MAIDEN NAME First Middle Last — — —									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 065 09 1625		17. INFORMANT JOAN H. BARTLETT			Address # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 2-3 days unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10/27, 1967 to 1/8, 1969 , that (I) (we) lost saw the deceased alive on 1/8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE R. I. Hochman, M.D.						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/9/69		
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M. D.						22e. ADDRESS 16 Murray Avenue, Annapolis, Maryland.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-11-69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION (City or Town) (County) (State) BLADESBURG P.G. MD.				
24. FUNERAL DIRECTOR John M. Lytton						ADDRESS Annapolis Md.		25a. REC'D BY REGISTRAR DATE JAN 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

VR 15/4/69
45M 1/69

00110

OFFICE OF THE ATTORNEY GENERAL

STATE OF ARIZONA

CLERK

March 1, 1900

White

Male

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

Armed and Dangerous

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) CURLEY						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 1-1 19 69			2b. HOUR M			
3. SEX Male		4. RACE American Indian		5. DATE OF BIRTH 10-26-1941		6. AGE (in years last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) TENN			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL			
10. CITY OR TOWN OF DEATH Jessup P.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Simms Lane				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 175		
14. FATHER'S NAME First CURT Middle BELL Lost BENTON				15. MOTHER'S MAIDEN NAME First DEANNA Middle DEANNA Lost DEANNA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 408-64-8814		17. INFORMANT Arch Bell ADDRESS SNEDSVILLE RT 4 TENN						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF (b) 970X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 970X DUE TO, OR AS A CONSEQUENCE OF (c) 970X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 7:00 P.M. 1-1 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 of Part 2, Item 18.) Shot in gun battle after shooting his wife and two police officers						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Simms Lane				21f. LOCATION Street or R.F.D. No. Simms Lane		City or Town Anne Arundel		State Md.		
22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles S. Springate				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED January 2, 1969				
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
ADDRESS (Street, city, town, or county) Hagerstown, Md.				ADDRESS (Street, city, town, or county) Ellicott City, Md.				ADDRESS (Street, city, town, or county) SNEDSVILLE, HANCOCK TOWN				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-5-68		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEM. FAIRVIEW				23d. LOCATION (City or Town) (County) (State) SNEDSVILLE HANCOCK TOWN				
24. FUNERAL DIRECTOR Hagerstown, Md.				25a. REC'D BY REGISTRAR IAN 7 1969				25b. REGISTRAR'S SIGNATURE [Signature]				

THE STATE
OF TEXAS
COUNTY OF DALLAS

11100

DEED OF TRUST AND MORTGAGE

11100

11100

DEED OF TRUST AND MORTGAGE

11100

11100

11100

11100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) JOHN First BEREZNE Last						2a. DATE OF DEATH JANUARY Month 30 Day 1969 Year			2b. HOUR 6:30 P.M.			
3. SEX male		4. RACE Cau.		5. DATE OF BIRTH January 19-1898			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel			Md.			
10. CITY OR TOWN OF DEATH Glen Burnie,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Conv. Ctr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor-Retired Armco			12b. KIND OF BUSINESS OR INDUSTRY Steel Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2911 Ritchie Ave. Baltimore 21219		
14. FATHER'S NAME First Michael Middle Berezne Last				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Glinski Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) Yes (Not During War Time)				16b. SOCIAL-SECURITY NO. 216-03-0904		17. INFORMANT (Wife) Mrs. Suzanna Berezne, 2911 Ritchie Ave.			21219 Address Edgemere, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple CVA's 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD & Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Jack I. Stern, MD DEGREE M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/30/69				
22d. PHYSICIAN'S NAME (Type) JACK I. STERN, MD						22e. ADDRESS 425 S.E. Ritchie Hwy Glen Burnie, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/3/69		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. RECEIVED BY REGISTRAR FEB 3 1969 DATE		25b. REGISTRAR'S SIGNATURE [Signature]				

00112

STATE OF DEATH

00112

January 30 1946

January

January

Can.

Male

January 17-1878

Age 68

U.S.A.

Glen Bueche, West Central Ave. Cte

MD

210-03-001

1946

1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1-1-69

00113		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00113					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
MICHAEL		BENEDICT		BLUM				JANUARY 17, 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		MARCH 21, 1881		87 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
MARYLAND		U.S.A.				ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE		304 CENTRAL AVE., N.W.		BARBER (ret.)		SELF EMP.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ANNE ARUNDEL		GLEN BURNIE				304 CENTRAL AVE., N.W.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
HENRY		BLUM						ALICE		MARINER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		//////////		212 34 8986		MRS. BARBARA BLUM (wife)		SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Bladder</u> 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 10</u> , 19 <u>50</u> , to <u>Jan 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. J. Mendelis M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-18-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>C. J. Mendelis</u>				22e. ADDRESS <u>2308 Edmondson Ave Balto. Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN. 21, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City or Town) (County) (State) <u>GLEN BURNIE, MD.</u>					
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND		25a. RECEIVED BY REGISTRAR DATE <u>JAN 22 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

00113

MICHAEL BENEDICT BLUM JAN 11, 1968

WHITE MALE 1007 ST, 1001 ST

U.S.A. 1007 ST, 1001 ST

304 CENTRAL AVE., WIL. BARBARA (MRS.)

MONMOUTH, NEW JERSEY 08054

NEWARK, NEW JERSEY 07102

NO. 1007 ST, 1001 ST, 1007 ST, 1001 ST

RECEIVED JAN 11, 1968 NEW YORK

NEW YORK, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
Beulah			C.		Bowser	Month Jan. Day 18 Year 1969			8:40 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
F		W		November 28, 1886		82 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Bay Manor			Housewife			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Glen Burnie				219 Poplar Avenue	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Seth			Brooks			Amanda			Redding
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
Yes, no, or unknown				Mr. George Bowser, 4012 Raleigh Road 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>Arteriosclerotic Cardiovascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>and</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Chronic emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26, 1968</u> , to <u>Jan 18, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Jan 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ray M. Smith</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 18, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>Ray M. Smith M. D.</u>					22e. ADDRESS <u>Hahn Professional Bldg., Severna Park, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Md.			
BURIAL		1-21-1969		Glen Haven Cemetery		Glen Burnie, Anne Arundel Co.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Ave 21229					JAN 21 1969		Charles Judge		

00112

00112

1959 JAN 10 1000 AM
RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

Pharmaceutical Corporation

Medical supplies

Jan 12 1959

Dr. J. H. Smith

X

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

1959 JAN 10 1000 AM
RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00115					00115						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR P.			
First		Middle		Last	Month		Day	Year	1:45 M		
Hazel Louise Brady					January		18, 1969				
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		White			May 1, 1921			47 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		U. S. A.					Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Harwood			Box 43			Housewife			Tenant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			A.A.			Harwood				Box 43	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
First		Middle		Last	First		Middle		Last		
Thomas		Edgar		Hagan	Mary		--		Higgs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No			--			Box 43, Archie Brady- Harwood, Maryland:					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral embolus									1 hr		
DUE TO, OR AS A CONSEQUENCE OF											
(b) Ch Pancreatitis									6 yrs		
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1950, to 18 Jan, 1969, that (I) (we) last saw the deceased alive on 16 Jan, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Robert B. Sasscer, M. D.										1/18/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Robert B. Sasscer, M. D.						Upper Marlboro, Md. 20870					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1/21/69		St. Matthew's Cem:			Seat Pleasant (Pr. Geo), Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.								JAN 29 1969		Charles Judge	

21106

CONFIDENTIAL

90/51/1

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research. It also provides a brief overview of the methodology used in the study.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00116

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00116

1. DECEASED-NAME (Type or print) Jennie			First Middle Last			2a. DATE OF DEATH Month 1 Day 2 Year 69			2b. HOUR 5:15p M		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 10/26/73			6. AGE (In years last birthday) 95 YRS.		
7a. BIRTHPLACE (State or foreign country) unknown			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY BALTO			13c. CITY OR TOWN White Marsh			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER unknown			14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. unknown			17. INFORMANT Hospital Records, Crownsville, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Dehydration, Uremia, Senile Brain disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 64 , to 1/2 , 19 69 , that (I) (we) last saw the deceased alive on 1/2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alberto Gonzalez						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/3/69		
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez						22e. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/7/69			23c. NAME OF CEMETERY OR CREMATORY Mt. Zion			23d. LOCATION (City or Town) (County) (State) Longview, Md. (Balt. Co.)		
24. FUNERAL DIRECTOR John L. Chaturan Jr - 1701 Mt. Cullough St						ADDRESS Balt. Md.			25a. FILED BY REGISTRAR JAN 6 1969		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

VA 1-514
30M REV 1-68

31100

31100

EX-100-111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00117

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00117

1. DECEASED-NAME (Type or print) Charles Frederick BRIGGS			2a. DATE OF DEATH Month January Day 30 Year 1969			2b. HOUR 3:30 M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 17, 1916		6. AGE (In years last birthday) 52 YRS.	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electronic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1505 Circle Drive							
14. FATHER'S NAME First GEORGE Middle HENRY Last Briggs			15. MOTHER'S MAIDEN NAME First Minnie Middle Busch Last Busch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, na, or unknown		16b. SOCIAL SECURITY NO. 4109		17. INFORMANT JANE B. Briggs #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart failure + stroke. 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/27 , 19 69 , to 1/30 , 19 69 , that (I) (we) last saw the deceased alive on 1/30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE General Blumel				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/29/69	
22d. PHYSICIAN'S NAME (Type) General Blumel				22e. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 2-1-69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Shadensburg P.G. Md.	
24. FUNERAL DIRECTOR John M. Lyles & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE James J. Jones	

00117

UNITED STATES DEPARTMENT OF JUSTICE

11-11-61

TO: SAC, NEW YORK (100-100000)
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

100-100000-1000
FEB 1 1962

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00118

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00118

1. DECEASED-NAME (Type or Print) <i>William</i> First <i>Briscoe</i> Middle <i>Briscoe</i> Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 1-5 1969			2b. HOUR <i>M</i>		
3. SEX <i>Male</i>			4. RACE <i>Col.</i>			5. DATE OF BIRTH 4-2-1915 53 YRS.		
6. AGE (In years last birthday) 53			IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>5</i>			IF UNDER 24 HRS. HOURS <i>1</i> MIN <i>5</i>		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH <i>D.C.</i>			10. CITY OR TOWN OF DEATH <i>West River</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Box 33</i>		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>MD</i>		
13b. COUNTY <i>D.C.</i>			13c. CITY OR TOWN <i>West River</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME First <i>George</i> Middle <i>Briscoe</i> Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>21456-0116</i>			17. INFORMANT <i>Rev. Owens</i> ADDRESS <i>West River MD</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Stroke</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i>19</i> P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <i>City or Town</i> <i>County</i> <i>State</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>1-5-69</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)			DATE <i>JAN 15 1969</i>			25b. REGISTRAR'S SIGNATURE <i>William Reese</i>		
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>1-7-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>House of Prayer</i>		
23d. LOCATION (City or Town) <i>West River MD</i>			23e. (County) <i>MD</i>			23f. (State) <i>MD</i>		
24. FUNERAL DIRECTOR <i>William Reese</i>			ADDRESS <i>West River MD</i>			25a. JAN 15 1969		

81100

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1912

PLANT
INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00119									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JOHN FALES BROOKS SR.						JAN 6 1969			11 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
MALE		WHITE		MAR 2 1899		69 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ANNAPOLIS		USA.				ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
ANNAPOLIS			A.A. GEN. HOSP.			CHEMIST			US Gov.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MD			A.A. Co.		EPPING FOREST				100 BROOK PATH
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN GEORGE BROOKS			MARY NADIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					MRS NAOMI E. BROOKS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(b) HYPERTENSIVE HEART DISEASE									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-1-68, 1968, to 1-6-69, 1969, that (I) (we) last saw the deceased alive on 12-17-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Edward Beck MD			1-6-69.						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			JAN 9, 1969		CEDAR BLUFF CEM		ANNAPOLIS MD		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
JOHN M. TAYLOR, SONS ANNAPOLIS MD			JAN 9 1969			[Signature]			

01100

CERTIFICATE OF DEATH

01100

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 7 & 13 Film 408
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
00120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00120

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR		
John				Brown	MAY 1 11 1969				1	11	1969	PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
M	N	3-4-17		51 YRS.	MONTHS		DAYS		1		11	1969	PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
N. Carolina		USA				Anne Arundel Co. Md.								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie				DOR-NORTH. ARUNDEL.										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Maryland				Anne Arundel		Baltimore				301 Bolivar St.				
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MARDEN NAME				First	Middle	Last	
William Morehead							Roxie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS				
				216-01-8570		Dorothy Brown				301 Bolivar St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) 4124														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) Chronic Toxic Poison														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				M.D.				1-11-69						
E. Linhardt								ANC						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial				1/16/69		Baltimore Natl. Baltimore Md								
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Charles A Rice				6614 Barres				DATE JAN 13 1969		Charles Judge				

60180

UNITED STATES DEPARTMENT OF HEALTH

FOR THE

DEPARTMENT

Handwritten signature

DATE: 1 JAN 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00121										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00121																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
John E. Bruckman										Jan. 14, 1969										4:20 P.M.																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH 11 March 1894										6. AGE (In years last birthday) 74 YRS.																			
7a. BIRTHPLACE (State or foreign country) Pennsylvania										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.																			
10. CITY OR TOWN OF DEATH Glen Burnie, Md.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waymaster - Retired										12b. KIND OF BUSINESS OR INDUSTRY RR																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY AA										13c. CITY OR TOWN Glen Burnie										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 107 Main Avenue S. W.									
14. FATHER'S NAME First Middle Last Franklin D. Bruckman										15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Ritchie																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no										16b. SOCIAL SECURITY NO. 171-07-8795										17. INFORMANT Mrs. Eloise Kellenberger, same as 13																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4109										IMMEDIATE CAUSE (a) Myocardial Infarction										1 day.																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF																																							
										(c) DUE TO, OR AS A CONSEQUENCE OF																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 1-1-67, to 1-16-67, that (I) (we) last saw the deceased alive on 1-1-67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Herbert Mueller MD DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 1-16-69																													
22d. PHYSICIAN'S NAME (Type) Herbert Mueller, M. D.										22e. ADDRESS Parkton, Maryland																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 18 Jan. 69										23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial										23d. LOCATION (City or Town) (County) (State) Elkridge, Howard, Md.																			
24. FUNERAL DIRECTOR										ADDRESS Kirkley Funeral Home, Glen Burnie, Md.										25a. REC'D BY REGISTRAR DATE JAN 17 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23d FilmG409

3/13/69 jp 00122

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00122

1. DECEASED-NAME (Type or print)		First Robert	Middle L.	Last Brusberg	2a. DATE OF DEATH Month Day Year January 31, 1969		2b. HOUR M
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 5, 1924		6. AGE (In years last birthday) 45 YRS.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co.	
10. CITY OR TOWN OF DEATH North Linthicum		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 308 Regency Circle		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician Fisher Body Car Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Eldo Brusberg		15. MOTHER'S MAIDEN NAME First Middle Last Alma Piaget					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 1943- 1946		17. INFORMANT Linthicum, Md. Mrs. Elizabeth A. Brusberg 308 Regency Circle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Adenocarcinoma of Pancreas 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none							
19a. DATE OF OPERATION July 28, '68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma Pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 28, 1968 , to Jan 31, 1969 , that (I) (we) last saw the deceased alive on Jan 31, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. Roderick Shipley MD				22c. DATE SIGNED February 2, 1969		22d. PHYSICIAN'S NAME (Type) E Roderick Shipley MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1969 Feb. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Cem.		23d. LOCATION (City or Town) (County) (State) Morgantown, W. Va. Md.	
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike				25a. RECEIVED BY REGISTRAR DATE FEB 8 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

00132

00132

00132

January 21, 1963

Hamburg

1.

Robert

42

Jan. 2, 1964

White

Male

Home National Co.

U. S. A.

West Virginia

Director of the Federal Bureau of Investigation

203 Maryland Avenue

North Washington

203 Maryland Avenue

Washington

Home National

Mr.

Prager

Miss

Hamburg

Miss

Washington, D.C.

100-1-100 333-64-1108 Mrs. Elizabeth A. Hamburg 203 Maryland Avenue

Washington

Home National

1963

Feb. 1, 1963

Miss

2, William Howard Ship Estate, National Bank

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00123

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00123

1. DECEASED-NAME (Type or print) First Middle Last Thomas ✓ Buczek Jan.			2a. DATE OF DEATH Month 18 Day 18 Year 1969		2b. HOUR 10 ¹⁵ P. M.						
3. SEX M		4. RACE W		5. DATE OF BIRTH 9-27-88		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel A.A. Md.					
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) C.S.H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) foundry worker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 3802 Hamilton Ave Baltimore				13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Buczek			15. MOTHER'S MAIDEN NAME First Middle Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. XXXXXXXXXXXX 206-07-9158A		17. INFORMANT Domenica Ann Buczek, 3802 Hamilton Ave.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease over 2 yrs. (c) Generalized Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous C.V.A. about 2 yrs ago											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from 5/26, 1968, to 1/18, 1969, that (we) last saw the deceased alive on 1/18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE Pixale Cerman			DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/19/69				
22d. PHYSICIAN'S NAME (Type) PIXALE CERMAN			22e. ADDRESS CROWNSTOWN STATE HOSP.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-21-69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION (City or Town) (County) (State) Balto., Md.				
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.					25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE John J. Judge				

85100

13-3

200-1-1000

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1-2-49

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15-14
45M - 1-69

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00124										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00124																			
Item 8 Film G408 1/17/69 kk										CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First James					Middle Linwood					Last BULLEN					2a. DATE OF DEATH Month January Day 12 Year 1969					2b. HOUR P. 2:02 M														
3. SEX Male					4. RACE White					5. DATE OF BIRTH July 13, 1925					6. AGE (In years last birthday) 43 YRS.					IF UNDER 1 YEAR MONTHS DAYS 					IF UNDER 24 HRS. HOURS MIN 														
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel																								
10. CITY OR TOWN OF DEATH Annapolis					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dead on arrival Anne Arundel Gen. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civil Service					12b. KIND OF BUSINESS OR INDUSTRY US Gov't																								
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland					13b. COUNTY Anne Arundel					13c. CITY OR TOWN Annapolis					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 510 Harbor Drive Hillsmere Shores.																			
14. FATHER'S NAME LAURENCE C. BULLEN					First Middle Last 					15. MOTHER'S MAIDEN NAME HATTIE A. VARTEN					First Middle Last 																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES					(If yes give war or date of service) WWII - IEP					16b. SOCIAL SECURITY NO. 219-12-3296					17. INFORMANT Dorothy Ann Bulhen # 13																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Sudden death (Very sudden) DUE TO, OR AS A CONSEQUENCE OF (b) Known Severe Cor. Art. disease DUE TO, OR AS A CONSEQUENCE OF (c) ASCD - Had 2 Coronaries past year															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 seconds 1 1/2 years																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Fall 1967; Coronary Spring 1968																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Fall 1967 to Present , 19 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Peter F. Verkouw MD															22c. DATE SIGNED 1-13-1969																								
22d. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M.D.															22e. ADDRESS 1407 Forest Drive, Annapolis, Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 1-15-69										23c. NAME OF CEMETERY OR CREMATORY St Marys										23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.									
24. FUNERAL DIRECTOR John M. Lohr Sons Annapolis, Md															25a. REC'D BY REGISTRAR DATE JAN 15 1969															25b. REGISTRAR'S SIGNATURE Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00125					00125					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. STATE			b. COUNTY		
Anne Arundle Co. Maryland			Dorsey		Maryland			Anne Arundle		
			c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
			Life					Dorsey		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
Race Road Box #12 Hanover P.O.					Dorsey Rd. Race Road Box #12 Hanover P.O.					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
Andrew Butler					Jan 11, 19 69					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/17/1889		79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Trackman- Ret			B. & O Railroad		Dorsey, Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Harry Butler					Rachel Burley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No			No		705-07-5885			Race Road		
					Mrs. Martha Butler Box #12 Hanover P.O.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Cardiac-Vascular Disease 5 yrs										
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 10 yrs										
(c) Blind for 2 years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1/14/1969, to 1/11/1969 that (1) (we) last saw the deceased alive on 1/11/1969, and that death occurred at 7:30 PM, from the causes and on the date stated above.					22a. SIGNATURE Dr. Bruce B. Brumbaugh M.D.					22b. DATE SIGNED 1/14/69
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Dr. Bruce B. Brumbaugh					5609 Main Street- Elkridge Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			1/15/69		Saints Rest Cemetery			Harmons, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE
Herbert E. Nutter-3035 W. North Ave.					JAN 21 1969					Charles Judge

00123

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00126

CERTIFICATE OF DEATH

00126

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P			
Minty Snowden					BUTLER	January 8, 1969			1:05 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		March 23, 1896			72 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U.S.A.				Anne Arundel County Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis			Anne Arundel Gen. Hospital			Seafarers						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Anne Arundel			Annapolis				411 Chesapeake Avenue		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Solomon			MIN		Snowden	Margaret			Lucinda		Price	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT						
No			214-05-1660			Annapolis, Md. Daisy Snowden-Harbour House Apts. 1155-aptS4						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left lower lobe Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the lungs with</u> (c) <u>Melanoma to the brain</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Raymond L. Richardson</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/10/69</u>				
22d. PHYSICIAN'S NAME (Type) Raymond L. Richardson, M. D.						22e. ADDRESS 110 Clay Street, Annapolis, Maryland.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Jan. 11-69		Pine Lawn - Cemetery			Annapolis, Maryland				
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Maryland						25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

00132

STATE OF NEW YORK

00132

IN SENATE, January 1, 1930.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF THE INTERIOR.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF AGRICULTURE.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF COMMERCE.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF EDUCATION.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF LABOR.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF SOCIAL WELFARE.

AND

REPORT OF THE COMMISSIONERS OF THE DEPARTMENT OF TAXATION.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

This mother is unwed and does not desire to name the baby.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00127 CERTIFICATE OF DEATH 00127									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Raychele Denile Butler						January 29 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		Jan. 29, 1969		YRS.		0 30	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Newborn					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Annapolis				1184 President St.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Robert Sylvester Wilson						Angela Denile Butler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		None		Hospital Records.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature Labor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 12 hrs. 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) this hospital attended the deceased from <u>Jan. 29, 1969</u> , to <u>Jan. 29, 1969</u> , that (I) was last saw the deceased alive on <u>Jan. 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard E. Cook</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/30/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Richard E. Cook, M.D.</u>					22e. ADDRESS <u>20 Dean St., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-2-1969		Brewer Hill		Annapolis A.A. Co Md			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
C.E. Hicks, 111 Annapolis, Md					FEB 5 1969		<u>Richard E. Cook</u>		

00127

REPUBLIC OF DENMARK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First JAMES			Middle LOUIS			Last CAIN		
2a. DATE OF DEATH			1			Month 20			Day 69 Year		
2b. HOUR			6;45			P					
3. SEX		Male		4. RACE		White		5. DATE OF BIRTH		10/3/1914	
6. AGE (In years lost birthday)		54		YRS.				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MONTHS		DAYS		HOURS		MIN					
7a. BIRTHPLACE (State or foreign country)			Maryland			7b. CITIZEN OF WHAT COUNTRY?			U. S. A.		
8. MARRIED			<input checked="" type="checkbox"/> NEVER MARRIED			<input type="checkbox"/> WIDOWED			<input type="checkbox"/> DIVORCED		
9. COUNTY OF DEATH			Anne Arundel								
10. CITY OR TOWN OF DEATH			Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			D.O. A. North Arundel		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY			Taxi		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			Md.			13b. COUNTY			A. A.		
13c. CITY OR TOWN			Glen Burnie			13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			1532 Tieman Drive								
14. FATHER'S NAME			First James			Middle L.			Last Cain		
15. MOTHER'S MAIDEN NAME			First Clara			Middle Pancoast			Last Pancoast		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			No.			16b. SOCIAL SECURITY NO.			217 05 9994		
17. INFORMANT			Address			1417 Rowe Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
4100 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Hypertensive Cordis omnia Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 6</u> , 19 <u>66</u> , to <u>Jan. 20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		H. P. Friedman		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		H. P. FRIEDMAN M.D.		22e. ADDRESS		1319 L. CHURCH ST. BALT. MD. 21230					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/23/69		Mt. Holly Cemetery		Onancock, Virginia					
24. FUNERAL DIRECTOR		Raymond C. Fink		Glen Burnie, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE		JAN 23 1968			

00128

LOUISIANA

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CAR

LOUIS

JAMES

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LOUISIANA

WHITE

Male

James Alexander

Married 0. 2. 1961

John Burns, 8. 7. 1907, North Central Commercial

Mc. A. A. Glen Burns, 1233 Tenth Drive

Phoenix

Class

Cain

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James

Six 02 9894 Willard Cain 1417 Rose Dr.

10.

Shirley, Virginia

W33109 M. Holly Rembert

May 1961

Raymond C. Link Glen Burns, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Charles Ottis CARROLL						January 28 1969			6:00 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male		Negro		July 3, 1884		84 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Nurse					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		156 Bestgate Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Franklin Carroll			Elizabeth Carroll						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Charles Carroll		Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage (VA)</u> 4122									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive ABCD</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 27, 1969, to Jan 28, 1969, that (I) (we) lost saw the deceased alive on Jan 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
PETER F. VERKOUW MD								1-29-1969	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
PETER F. VERKOUW		1407 Forest Drive, Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) County State			
Burial		2-1-1969		Fowlers		Chesapeake City, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Reese		Chesapeake City, Md.		FEB 3 1969		Charles Judge			

00122

00122



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00130

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00130

1. DECEASED-NAME (Type or Print)				First Middle Last				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR					
WALLACE				E.				CARROLL				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR			
Male		Negro		5/26/34		34 YRS.						January 26, 1969		1:30 A.M.			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Maryland				U.S.A.								Anne Arundel Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis				Anne Arundel Gen. Hospital													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Prince Georges				Upper Marlboro						General Delivery			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
James R. Carroll				Essie													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT									
				215-30-6460				James R. Carroll Box 3384 Upper Marlboro, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
965X Gunshot wound of thorax																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				12:00 1/26 19 69				?									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
				Parking Lot				River Bend Inn Lothian Anne Arundel Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 27, 1969					
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				2-1-69		St. Mary's Church Ceme.				Croom, Maryland							
FUNERAL HOME				4339 Hunt Pl., N.E.				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
								DATE JAN 30 1969				Charles J. Jones					

HEALTH
702 7411

00130

00130

MEDICAL EXAMINER - CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, CITY AND COUNTY OF DENVER

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES B. DOLAN, JR.		M		38		JAN 10 1968		HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
1011 E. WYOMING ST.		ENGINEER		HEART DISEASE		NATURAL		[Signature]	
CITY AND COUNTY OF DENVER		STATE OF COLORADO		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		MEDICAL EXAMINER'S SIGNATURE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00131

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00131

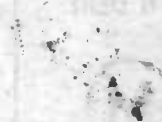
1. DECEASED-NAME (Type or Print) Roy			First V			Middle CASSEL			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month 1 Day 24 Year 1969			2b. HOUR A M					
3. SEX M		4. RACE W		5. DATE OF BIRTH 11-13-14		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		2c. DATE PRONOUNCED DEAD Month 1 Day 24 Year 1969		2d. HOUR A M			
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH A.A. CO					
10. CITY OR TOWN OF DEATH 99 Glen Burnie				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA-NORTH ARONDEL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY A.A.				13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Green Gables Rt 1 Box 110					
14. FATHER'S NAME First Roy H. Cassel						Middle 						Lost 					
15. MOTHER'S MAIDEN NAME First Mary Watts						Middle 						Lost 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				(If yes give way or dates of service) WW 2				16b. SOCIAL SECURITY NO. 215-07-4982				17. INFORMANT ADDRESS Mrs Mary E. Cassel Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5719 Leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Prostate					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State 									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE E. Linhardt				EXAMINER'S NAME (Type) E. Linhardt				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 1-24-69					
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
								ADDRESS (Street, city, town, or county) A.A. CO.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/28/69				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City or Town) (County) (State) Baltimore Co, Md.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks West Inc 6212 Balt. Nat Pk				ADDRESS Balt Md. 21228				25a. REC'D BY REGISTRAR JAN 31 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

00131

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

00131

00131



TO : DIRECTOR, FBI (100-388610) FROM : SAC, NEW YORK (100-100000) (P)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

DISSEMINATION: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00132		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00132	
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		
First		Middle		Last		2b. HOUR	
Freida		E.		Cathcart		Jan 24 1969 7:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		White		11-24-04		64 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.				Anne Arundel Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel		Housewife		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		AA		Pasadena		8430 Church Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Henry Hansel		Anna Mendel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No		218-28-6711		Mrs. Glenda Klauzowski -1704 Lansing Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Extensive Tuberculosis</i>							<i>Days</i>
485X DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<i>Moderately severe obstructive lung disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		Hour A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-24</i> , 19 <i>69</i> , to <i>1-24</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>1-24</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
<i>Alley M. [Signature]</i>				<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		<i>1-24-69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
		N. Arundel Hosp/					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Jan. 27, 1969		Glen Haven Mem. Pk.		Glen Burnie, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonce		4001 Ritchie Hwy.		DATE JAN 29 1969		<i>Charles Judge</i>	

00133

00133

00133

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00133		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00133	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
CAROLINE V. CHANEY					Month Day Year 9 JAN 10 1969 4:10 P.M.
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)
F	Caucasian		4/21/1888		80 YRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
MARYLAND		U.S.A.		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNAT. NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY A.A. Co ANNAPOLIS		13c. STREET AND NUMBER 311 WASHINGTON ST.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
J B OGDEN		JULIA COLLISON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 022408789J		17. INFORMANT Address MR. HOWARD T. CHANEY #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis					
4124 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Cardiovascular disease					2 days
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of colon					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 9 1969, to Jan 10 1969, that (I) (we) last saw the deceased alive on Jan 9 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ray M. Smith		DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 10 1969	
22d. PHYSICIAN'S NAME (Type) RAY M. SMITH		22e. ADDRESS HARRIS PROF. BLDG SUVERNA PK MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/12/1969		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.	
23d. LOCATION (City or Town) ANNAPOLIS		(County) A.A. Co		(State) MD.	
24. FUNERAL DIRECTOR ADDRESS JOHN M. TAYLOR-SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR DATE JAN 14 1969		25b. REGISTRAR'S SIGNATURE	

00134

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00134

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
JAMES			E.			CHESNUTT			19 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
male	negro	March 28, 1930	38 YRS.					January 19, 1969			1:10 A. M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Conway S.C.			USA						Anne Arundel Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General Hosp.								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Anne Arundel			Annapolis			604 Lreams Landing		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Jerry Chestnut			Mahalia Stanley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)			17. INFORMANT ADDRESS					
No						Salmon J. Home			B.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stabwound of Neck</u> <u>966 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:00 PM 1/19 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. stabbed in neck by wife					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) parking lot			21f. LOCATION Street or R.F.D. No. City or Town County State Annapolis, Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.			EXAMINER'S NAME (Type)			22b. DATE SIGNED 1/19/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1-30-69			South Carolina			Conway South Carolina		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Salmon J. Home			S. Carolina			DATE JAN 31 1969			Charles Judge		

00134

RECORDS EXAMINER'S OFFICE

00134

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00134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR
45M

00135										00135											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR	
First Kathleen			Middle P.			Last CHITTY				Month January				Day 7		Year 1969		9:25 M			
3. SEX Female			4. RACE White			5. DATE OF BIRTH October 7, 1892				6. AGE (In years last birthday) 76 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) England			7b. CITIZEN OF WHAT COUNTRY? ENGLAND			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel County Md.											
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital							12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Mayopolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 301 Maple Street, Beverly Beach,											
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-48-9112			17. INFORMANT AGNES P. WILLIS				Address 3100 MASS. AVE., N.W. WASHINGTON, D.C.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus Fractured Ankle</u>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1/5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u>												DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/8/69					
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M. D.						22e. ADDRESS 16 Murray Avenue, Annapolis, Maryland.															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN 15 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY				23d. LOCATION (City or Town) (County) (State) COLMAR MANOR PRINE GEORGES MD.												
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC.						ADDRESS WASHINGTON, D.C.				25a. REC'D BY REGISTRAR DATE JAN 16 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

00132

UNITED STATES OF AMERICA

80132



00132

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Katherine			Middle B.		Last Coe		2a. DATE OF DEATH 1 Month 16 Day 69 eor		2b. HOUR 2A M			
3. SEX Female			4. RACE White			5. DATE OF BIRTH 6-5-04			6. AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH A.A.Co.						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Balto. County			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2540 Virginia Ave.						
14. FATHER'S NAME First James			Middle Taylor			Last Elmira			15. MOTHER'S MAIDEN NAME First Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Address William I. Coe, same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Mitral Valve Disease - possibly Rheumatic															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 12-24, 1968 , to 1-16-1969 , that (I) (we) last saw the deceased alive on 1-15-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Hilary T. O'Herlihy			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-16-69	
22d. PHYSICIAN'S NAME (Type) Hilary T. O'Herlihy M.D.			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 20 Jan. 69			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial			23d. LOCATION (City or Town) (County) (State) Glen Burnie, AA Md						
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.			ADDRESS			25a. REC'D BY REGISTRAR JAN 17 1969			25b. REGISTRAR'S SIGNATURE [Signature]						

10138

10138

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Ante-propositus & Affected

Chronic Mitral Valve Disease - probably Rheumatic

1-12 - 69 12-24 67 1-16 - 69

John J. [Signature]

1-16-69

10138 10138 10138 10138 10138 10138 10138 10138 10138 10138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item #8, Film G410 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film G410 3/7/69 kk 0013

CERTIFICATE OF DEATH

01837

1. DECEASED-NAME (Type or print) Courtney		2a. DATE OF DEATH Month 1 Day 24 Year 69		2b. HOUR 7:25a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8/8/04	6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) unknown		7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		9. COUNTY OF DEATH Anne Arundel Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last unknown		15. MOTHER'S MAIDEN NAME First Middle Last unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, Crownsville, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonai DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary T.B. (?) Chronic brain syndrome				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 68 , to 1/24 , 19 69 , that (I) (we) last saw the deceased alive on 1/24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Charles R. Venter, M.D.		22c. DATE SIGNED 1/24/69		22d. ADDRESS X Crownsville State Hospital, Maryland
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 2.24.69		23c. NAME OF CEMETERY OR CREMATORY Uofmd. Med. School
24. FUNERAL DIRECTOR		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		23e. REC'D BY REGISTRAR FEB 28 1969

70810

38-113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00138										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00137									
1. DECEASED-NAME (Type or print) First Middle Last Henry Becker COOKE, Sr.										2a. DATE OF DEATH Month Day Year January 12 1969										2b. HOUR M 1:00 M									
3. SEX Male			4. RACE White			5. DATE OF BIRTH Feb. 20, 1884					6. AGE (In years last birthday) 84 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel Md.														
10. CITY OR TOWN OF DEATH Annapolis					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) grocer					12b. KIND OF BUSINESS OR INDUSTRY self empl.														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Anne Arundel					13c. CITY OR TOWN Gambrills					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER ---									
14. FATHER'S NAME First Middle Last Augustus Gambri ll Cooke					15. MOTHER'S MAIDEN NAME First Middle Last Unknown																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no.					16b. SOCIAL SECURITY NO. 137-05-6231					17. INFORMANT Address Mary Cooke Sands - same as #13 above																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 4339 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (1) (this hospital) attended the deceased from <u>15 MAR, 1968</u> , to <u>12 JAN, 1969</u> , that (1) (we) last saw the deceased alive on <u>12 JAN, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Edward S. Beck</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 1-13-69														
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.										22e. ADDRESS 73 Franklin St., Annapolis, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 1/14/69					23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery					23d. LOCATION (City or Town) (County) (State) Millersville 4.4 Md.														
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME - Annapolis, Md.										25a. REC'D BY REGISTRAR JAN 15 1969					25b. REGISTRAR'S SIGNATURE James J. Judge														

00137

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00139					00138				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Joseph			F.		Cousler	1 = 31 69			7:30a M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		9/29/24		44 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		US A				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Crownsville		Crownsville State Hospital		Fireman Patapsco & Back River RR					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balto		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		315 Kresson Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James					Cousler	Margaret			Bruner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			216-16-8457		Hospital Records, Crownsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Severe acute pulmonary edema, congestion and</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>focal atelectasis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Tracheo-bronchial aspiration of gastric content</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>chronic brain syndrome. Focal pneumonia; dilation of stomach</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28, 19 65</u> , to <u>1/31, 19 69</u> , that (I) (we) last saw the deceased alive on <u>1/31, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Charles R. Venter, M.D.</u>									<u>2/3/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Charles R. Venter, M.D.					Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/5/69		Balto. National Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
John J. Duda, 7922 Wise Ave. Dundalk, Md.							FEB 5 1969		<u>Charles Judge</u>

88100

RECEIVED

1961

1

1

10-10-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00140		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00139	
Items 6&14 Film 409 1/29/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
Frank		Bawson		Month 1 Day 24 Year 69	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		6/14/94	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (In years last birthday)	
Maryland		US		71 75 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		9. COUNTY OF DEATH	
Crownsville		Crownsville State Hospital		Anne Arundel Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. INSIDE CITY LIMITS?	
Md		Balto		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER	
First Middle Last		First Middle Last		31 West Preston Street	
Abraham Dawson		Elizabeth Kedge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
no		214-05-6208		Hospital Records, Crownsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Carcinoma of lung					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Cardiovascular disease, Cardiac arrhythmia					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Malnutrition					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		HOUR A.M. Month Day Year			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No. City or Town County State	
at work <input type="checkbox"/> at work <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 12/21, 1968, to 1/24, 1969, that (I) (we) last saw the deceased alive on 1/29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
[Signature]		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		1/24/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
		Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		1-27-69		Md. Med. School	
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WILLIAM M REESE		JAN 28 1969		[Signature]	
108 W. Washington St. Annapolis, Md		DATE			

00123

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

DEPARTMENT OF THE ARMY

1010



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00141										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00140									
Item 11 Film G409 2/13/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
MARY Louise DIXON										Jan 29 1969					M														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Female		white		May 4, 1927		41 YRS.		MONTHS		DAYS		HOURS		MIN.															
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH																					
WASH, D.C.		USA		WIDOWED		DIVORCED		Anne Arundel Co						Md.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																							
Edgewater		Rt. 3, Box 3F		WAITRESS		CAFETERIA																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER																					
Md		AA Co		Edgewater		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rte 3 Box 3F																					
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last																							
Charles J.		LENTZ		Magdeline		Mahoney																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address																					
				228-30-4622		Curtis Dye		Edgewater, Md																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Myocardial Failure										Unattended																			
DUE TO, OR AS A CONSEQUENCE OF																													
(b) Bronchial Asthma																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Obesity										Since Childhood																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																									
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year																											
		P.M. 19																											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State																	
While <input type="checkbox"/> Not while <input type="checkbox"/>																													
at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from July 19 63, to Jan 19 69, that (I) (we) last saw the deceased alive on Feb 18 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																							
W. F. Stephens M.D.		1-30-69		William Stephens M.D.		Cornhill St. Annapolis, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)																			
Burial		Feb 1, 1969		Beulah BAPTIST		FRANCONIA																							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																							
Hardesty Funeral Home, Annapolis, Md				FEB 3 1969																									

00100

Myocardial infarction
Pneumonia
Septic

✓

1-18-19
1-20-19
1-21-19
1-22-19
1-23-19
1-24-19
1-25-19
1-26-19
1-27-19
1-28-19
1-29-19
1-30-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01493										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Item 6 Film 410 3/5/69 kk										CERTIFICATE OF DEATH														
01845																								
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Thomas					Dodson					JAN • Month 25 Day 1969 Year					11:45 A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			White			8/17/91			18 YRS.			MONTHS DAYS HOURS MIN												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
unknown			US						Anne Arundel Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Crownsville					Crownsville State Hospital																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER								
Maryland					Balto					Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			839 S. Bond Street								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
unknown					unknown																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address														
unknown					unknown					Hospital Records, Crownsville State Hospital														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Shock																								
DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																								
(b) Pulmonary embolism																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c) Lt hip fracture.																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
Atherosclerosis of coronary vessels for disease. Pulmonary embolism.																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 19 68, to 1/25, 19 69, that (I) (we) last saw the deceased alive on 1/25, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
NICK P. MOUTSOR															1/25/69									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
NICK P. MOUTSOR																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Cremation					2.24.69					C. of Md. Med. School					Baltimore Md.									
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
															FEB 28 1969					Charles Judge				

31822

RECORD OF DEATH

31822

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ETHEL MARIE DORSEY			2a. DATE OF DEATH Month Jan Day 7 Year 1969			2b. HOUR 10 P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MAR 24 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Tracy's Landing			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY AA		13c. CITY OR TOWN Tracy's Landing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Clarence Middle Phillips Last Della			15. MOTHER'S MAIDEN NAME First Costerton Middle Costerton Last Costerton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 1		17. INFORMANT Address Dorothy Dempsey Arnold, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 61 , to Jan 7 , 19 69 , that (I) (we) last saw the deceased alive on Jan 7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Willard F. Smith				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/9/69					
22d. PHYSICIAN'S NAME (Type) Willard F. Smith				22e. ADDRESS Shady Side, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-10-69		23c. NAME OF CEMETERY OR CREMATORY MT Harmony		23d. LOCATION (City or Town) (County) (State) MT Harmony, Md.					
24. FUNERAL DIRECTOR Bernard Hardesty				ADDRESS Halesville Md.		25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

00151

RECEIVED - DEPARTMENT OF THE ARMY - WASHINGTON, D.C.

OFFICE OF THE ADJUTANT GENERAL

00151

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil after item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS; 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00143

00142

1. DECEASED-NAME (Type or Print) PATRICK			First Middle Last DORSEY			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year 1 1 1969			2b. HOUR 1 a m		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5 June 1950		6. AGE (In years last birthday) 18 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (State or foreign country) Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 1305 Catwood Rd.			13f. STREET AND NUMBER Catwood Rd.			13g. STREET AND NUMBER Catwood Rd.			13h. STREET AND NUMBER Catwood Rd.		
14. FATHER'S NAME Francis O. Dorsey			15. MOTHER'S MAIDEN NAME Elda H. Johnson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. no		
17. INFORMANT Father - same as 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries 815.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12 xx 1 1 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in auto-fixed object coll.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State Entrance Fort Smallwood Pk. A. A. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward F. Wilson			EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 1/1/69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4 Jan. 69			23c. NAME OF CEMETERY OR CREMATORY Cemetery Our Lady Of Sorrows Church			23d. LOCATION (City or Town) (County) (State) Owensville, AA, Md.		
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.			25a. REC'D BY REGISTRAR DATE JAN 6 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 155
30M REV. 1/60

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Roy		V		Dudley				January 25 1968		3:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		1-30-17		51 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Anne Arundel				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		1220 Crawford Dr.		Construction Foreman McLean Corp							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Anne Arundel		Glen Burnie				1220 Crawford Drive			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First	
Roy		V.		Dudley Sr.				Janie		Knight	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		229-07-7256		Mrs. Mary K. Dudley (wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4109				Myocardial Infarct							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		At main coronary occlusion					
				(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1966, to JAN 13, 1969, that (I) (we) lost saw the deceased alive on JAN 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Leon C. Perry MD.		1-26-69		Leon C. Perry MD		Glen Burnie, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 28 1969		Glen Haven Memorial Park		Glen Burnie, Maryland					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
E.B. Glatton		JAN 30 1969		Charles J. Jager		JAN 30 1969					
Singleton Funeral Home				Glen Burnie, Md.							

00123

EXHIBIT C

00123



00123

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00145												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00144											
Item 23 Film 409 2/10/69 kk												CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print) LAWRENCE						First Middle Last						2a. DATE OF DEATH JAN Month 22 Day 1969 Year						2b. HOUR 9:00 M																	
3. SEX Male				4. RACE Negro				5. DATE OF BIRTH 20 June 1946				6. AGE (In years last birthday) 22 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN															
7a. BIRTHPLACE (State or foreign country) Mississippi				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel Md.																							
10. CITY OR TOWN OF DEATH Fort George G. Meade				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Serviceman				12b. KIND OF BUSINESS OR INDUSTRY U.S. Army																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware				13b. COUNTY Kent				13c. CITY OR TOWN Frederica				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 201 Thomas																			
14. FATHER'S NAME Olin						First Middle Last Singleton						15. MOTHER'S MAIDEN NAME Catherine F. Neal						First Middle Last F. Neal																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes 1964-1968				16b. SOCIAL SECURITY NO. 222-28-9668				17. INFORMANT 201 Thomas, Frederica, Delaware Catherine F. Neal (mother)																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Myocardial Disease 428X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that 23 (this hospital) attended the deceased from 14 Jan , 19 69 , to 22 Jan , 19 69 , that 24 (we) last saw the deceased alive on 22 Jan , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE John J. Rothschild				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 22 Jan 1969																											
22d. PHYSICIAN'S NAME (Type) JOHN J. ROTHSCHILD, CPT, MC				22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD																															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1-28-69				23c. NAME OF CEMETERY OR CREMATORY Libb's Memorial Park				23d. LOCATION (City or Town) (County) (State) Camden Kent Md																							
24. FUNERAL DIRECTOR Ermy R. Reese				ADDRESS Dover Del				25a. REC'D BY REGISTRAR FEB 4 1969				25b. REGISTRAR'S SIGNATURE Charles Judge																							

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UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00146

00145

1. DECEASED-NAME (Type or print) First Middle Last Louis EBERLING		2a. DATE OF DEATH Month Day Year January 17 1969		2b. HOUR M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH June 5 1885	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Crownsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2211 McElderry Street
14. FATHER'S NAME First Middle Last George Eberling	15. MOTHER'S MAIDEN NAME First Middle Last Marie ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No	16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 212-657620	17. INFORMANT Address Medical Records - Crownsville State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 wk.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Dehydration and Uremia with Decubitus Ulcers				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from April 11 1966, to January 17 1969, that (I) (we) lost saw the deceased alive on January 17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Lionel M. Henry M.D.	22c. DATE SIGNED January 17 1969	22d. PHYSICIAN'S NAME (Type) Lionel M. Henry M.D.	22e. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-21-69	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	23d. LOCATION (City or Town) (County) (State) BALTO., MD.	
24. FUNERAL DIRECTOR Arthur Miller - 2331	25a. REC'D BY REGISTRAR DATE JAN 20 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		

00145

STATE OF TEXAS

00145



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00147

00146

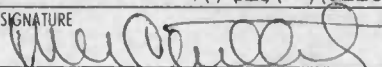
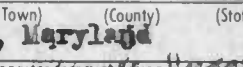
1. DECEASED-NAME (Type or print) RAYMOND LEE ELLIOTT			2a. DATE OF DEATH Month 1 Day 10 Year 69			2b. HOUR M 					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-3-85		6. AGE (In years lost birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANN ARUNDEL Md.					
10. CITY OR TOWN OF DEATH CROWNSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CROWNSVILLE STATE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 307 N GREEN		
14. FATHER'S NAME First Middle Last CHARLES ELLIOTT			15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA GIFFIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-14-4370A		17. INFORMANT HOSPITAL RECORD Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 492X DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7-22 , 19 68 , to 1-10 , 19 69 , that (I) (we) last saw the deceased alive on 1-10-69 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John J. M. Giffin, M.D. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-10-69			
22d. PHYSICIAN'S NAME (Type) CROWNSVILLE STATE HOSP						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-15-69		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Whitacre, Frederick Co, Va					
24. FUNERAL DIRECTOR Giffin Funeral Home, Capon Bridge, W. Va 26711						25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

1. Name of deceased: [illegible]
 2. Sex: [illegible]
 3. Age: [illegible]
 4. Date of birth: [illegible]
 5. Place of birth: [illegible]
 6. Date of death: [illegible]
 7. Place of death: [illegible]
 8. Cause of death: [illegible]
 9. Signature of physician: [illegible]
 10. Signature of witness: [illegible]

11. Signature of registrar: [illegible]
 12. Date of registration: [illegible]
 13. Place of registration: [illegible]
 14. Signature of informant: [illegible]
 15. Date of information: [illegible]
 16. Place of information: [illegible]
 17. Signature of informant: [illegible]
 18. Date of information: [illegible]
 19. Place of information: [illegible]
 20. Signature of informant: [illegible]
 21. Date of information: [illegible]
 22. Place of information: [illegible]

23. Signature of informant: [illegible]
 24. Date of information: [illegible]
 25. Place of information: [illegible]
 26. Signature of informant: [illegible]
 27. Date of information: [illegible]
 28. Place of information: [illegible]
 29. Signature of informant: [illegible]
 30. Date of information: [illegible]
 31. Place of information: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00148 CERTIFICATE OF DEATH 00147									
1. DECEASED-NAME (Type or print) LeRoy Hance EPPS			2a. DATE OF DEATH Month January Day 18 Year 1969			2b. HOUR P. 2:01 M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH January 18, 1969		6. AGE (in years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 1	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newborn		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt-1, Box 331,	
14. FATHER'S NAME First Donald Middle LeRoy Last Epps			15. MOTHER'S MAIDEN NAME First Linda Middle Rose Last Hance Gabriel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7709 IMMEDIATE CAUSE (a) Immaturity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Placental insufficiency DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from Jan. 18, 1969 , to Jan. 18, 1969 , that (I) (we) last saw the deceased alive on Jan. 18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE  DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1/21/69					
22d. PHYSICIAN'S NAME (Type) Nelson M. Chitterling, M.D.				22e. ADDRESS 95 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVING (Specify) Burial		23b. DATE Jan. 27-69		23c. NAME OF CEMETERY OR CREMATORY Balt. National U.S.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR C.E. Hicks III				ADDRESS Annapolis, Md.		25a. RECORD RECORDED JAN 28 1969		25b. REGISTRAR'S SIGNATURE 	

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00149

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00148

1. DECEASED-NAME (Type or Print) (or ^{First} Donald E.) ^{Middle} ^{Last} EDWARD D. FERRARI				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 1 13 19 69		2b. HOUR 1:45	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 21, 1924		6. AGE (In years last birthday) 44 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY a. a.		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME ^{First} ^{Middle} ^{Last} Edward Ferrari				15. MOTHER'S MAIDEN NAME ^{First} ^{Middle} ^{Last} Helen Stevens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. WW 2 216-16-8718		17. INFORMANT Donna Lee Ferrari, dght.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 815.0 IMMEDIATE CAUSE (a) Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 12:30 PM 1 13 19 69			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in auto-fixed object coll.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			
21f. LOCATION Street or R.F.D. No. City or Town County State Hammonds Lane Annapolis A. A. Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward F. Wilson, M.D.				22b. DATE SIGNED 1/13/69			
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/17/69		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				25a. REC'D BY REGISTRAR JAN 20 1969			
ADDRESS 3331 Brehms Lane				25b. REGISTRAR'S SIGNATURE Charles Judge			

Page 15 of 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15124
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Rosario (Robert)			Fertitta			January 12, 1969		8 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost in day)		IF UNDER 1 YEAR	
Male		White		July 20, 1892		76 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Italy		Italy				Anne Arundel, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done)		12b. KIND OF BUSINESS OR INDUSTRY	
Arnold			Shore Acres Drive			Self-employed Trucking			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Anne Arundel		Arnold		Shore Acres Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Vincent			Fertitta			Rosaria Micciche			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			216-32-6438		Louis Sabatino 925 B reezewick Circle				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY									
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DO TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF R LUNG									
DO TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8/27/68		Carcinoma R Lung			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug 27, 1968, to Jan 4, 1969, that (I) (we) lost the deceased on Jan 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
George G. Finney, Jr.					M.D.				1/13/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
George G. Finney, Jr. M.D.					5820 York Road				
23a. BURIAL CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Buried		1/15/69		New Cathedral Cem.		Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Balto. Md. 21214					JAN 13 1969		[Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00151

DIVISION OF VITAL RECORDS, 100 WESTON STREET, BALTIMORE, MARYLAND 21201

00150

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Sylvia Dale FETHERSTON			2a. DATE OF DEATH January Month 4 , Day 1969 Year		2b. HOUR P 10:54M
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 18, 1924	6. AGE (In years last birthday) 44 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel County Md.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 105 Claude Street	
14. FATHER'S NAME First Not Known Middle Not Known Last Not Known	15. MOTHER'S MAIDEN NAME First Not Known Middle Not Known Last Not Known				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. 471X	17. INFORMANT Mrs. Sylvia Jewell Address 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial 471X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chills DUE TO, OR AS A CONSEQUENCE OF (c) 10 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebrovascular accident.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 1969, to Jan , 1969, that (I) (we) lost saw the deceased alive on Jan 4 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John L. Hedeman		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1/5/69		
22d. PHYSICIAN'S NAME (Type) John L. Hedeman, M. D.		22e. ADDRESS 1407 Forest Drive, Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1-7-69	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City or Town) (County) (State) Annapolis Md.		
24. FUNERAL DIRECTOR John M. Taylor & Sons		ADDRESS Annapolis, Md.	25a. REC'D BY REGISTRAR DATE JAN 9 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

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1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 26

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153001 *Journal of General Internal Medicine* 1996;11:100-104

2017-2018

(continued)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a, Film G409 2		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or Print) CHARLES FISHER			
2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 28 Year 1969		2b. HOUR M	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 2/9/29	6. AGE (In years last birthday) 39 YRS.
7a. BIRTHPLACE (State or foreign country) Virginia U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bar Tender		12b. KIND OF BUSINESS OR INDUSTRY U.S. Officers Club	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel	
13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 39 Pinkney Street			
14. FATHER'S NAME First James Middle Fisher Last Fisher		15. MOTHER'S MAIDEN NAME First Mary Middle Fisher Last Fisher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16b. SOCIAL SECURITY NO. (Il yes give war or dates of service)	
17. INFORMANT Rachel Fisher - Anna Md.		ADDRESS Anna Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.	
EXAMINER'S NAME (Type)		22b. DATE SIGNED January 27, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/30/69	
23c. NAME OF CEMETERY OR CREMATORY Green Lawn Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24. FUNERAL DIRECTOR William Reese, Jr. - Anna Md.		ADDRESS Anna Md.	
25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 1 1969
30M REV. 1-68

00153										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00152									
Item #6, Film G409 1/30/69 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) First Middle Last John Fleetwood										2a. DATE OF DEATH Month Day Year 1/ 21/ 69										2b. HOUR 6:15 PM									
3. SEX Male					4. RACE Negro					5. DATE OF BIRTH 5/7/84					6. AGE (In years lost birthday) 85 8 1/2 YRS.					IF UNDER 1 YEAR MONTHS DAYS 85 8 1/2					IF UNDER 24 HRS. HOURS MIN 6:15				
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? US					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel Md.														
10. CITY OR TOWN OF DEATH Crownsville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Anne Arundel					13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER Rt 5, St. Margarets									
14. FATHER'S NAME First Middle Last Charles Fleetwood					15. MOTHER'S MAIDEN NAME First Middle Last Elsie Fleetwood																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16b. SOCIAL SECURITY NO. unknown					17. INFORMANT Address Hospital Records, Crownsville, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Lt. U. L. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD, decompensated DUE TO, OR AS A CONSEQUENCE OF (c) Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CA of the sigmoid, resected. Transurethral prostatectomy																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 11/21 , 19 65 , to 1/22/ , 19 69 , that (I) (we) last saw the deceased alive on 1/22/ , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Nick P. Moutsos					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 1/22/69																			
22d. PHYSICIAN'S NAME (Type) Nick P. Moutsos, M.D.					22e. ADDRESS Crownsville State Hospital, Maryland																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 1-25-1969					23c. NAME OF CEMETERY OR CREMATORY Broadneck					23d. LOCATION (City or Town) (County) (State) St. Margarets Md.														
24. FUNERAL DIRECTOR William Beese					ADDRESS Crina. Md.					25a. REC'D BY REGISTRAR JAN 24 1969					25b. REGISTRAR'S SIGNATURE Charles Judge														

00133

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00133

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00154				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00153							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR P	
Earlie C Forrester										January 16 1969				10:55M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		Negro		August 1, 1896				72 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Md.		U.S.A.				Anne Arundel									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Millersville		Knollwood Nursing Home		Retired											
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Md.		Chesapeake		Chesapeake											
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
David H. Forrester										Frances Hill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (No, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address									
Yes		579-01-1767		Frances Forrester		Chesapeake									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized carcinomatosis, carcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
1965		Carcinoma of colon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NA									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) <u>did not</u> attend the deceased from <u>January 9, 1969</u> , to <u>January 16, 1969</u> , that (I) <u>was</u> last saw the deceased alive on <u>January 15, 1969</u> , and that in (my <u>own</u>) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.												22c. DATE SIGNED			
22b. SIGNATURE		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE									
Charles W. Kinzer		Charles W. Kinzer, M. D.		16 Murravy Ave.		Annapolis, Md. 21401									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)									
Burial		1-21-1969		Balto. National Balto.		D.C.									
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
William Reesett		DATE		JAN 20 1969		Charles Judge									

00123

STATE OF NEW YORK

00123

IN SENATE
January 12, 1910
REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 15, 1909

ALBANY:
J. B. LEECH, JR.,
PRINTERS.
1910.

THE COMMISSIONERS OF THE LAND OFFICE
HONORABLE SENATOR
J. B. LEECH, JR.,
PRINTERS.
1910.

THE COMMISSIONERS OF THE LAND OFFICE
HONORABLE SENATOR
J. B. LEECH, JR.,
PRINTERS.
1910.

THE COMMISSIONERS OF THE LAND OFFICE
HONORABLE SENATOR
J. B. LEECH, JR.,
PRINTERS.
1910.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Enma			J.		FREEMAN	JAN Month 21 Day 1969 Year			- M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		JAN 5, 1880		89 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ANNAPOLIS MD		U.S.A.				ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
St. Margaret's		BAYMANOR NUR. HOME		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		AA. CO.		ANNAPOLIS				1 BLOOMS BURY SQ	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Z Z K E					MITCHELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No						JOSEPH FREEMAN			# 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (U) (this hospital) attended the deceased from June, 1955 to, 19, that (U) (we) last saw the deceased alive on 17 Jan 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) did (did not) view the body after death.									
22b. SIGNATURE Edward S. Beck					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-24-69
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.					22e. ADDRESS 73 Franklin St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN 24, 1969		ANNAP. NATIONAL CEM.		ANNAPOLIS MD			
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS					ADDRESS ANNAPOLIS MD		25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "OFFICE OF DEAN" and "00124" are visible.]



[Faint vertical text along the right edge, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00156

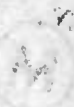
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00155

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last George Robert Fulda			2a. DATE OF DEATH Month 25 Day 1969 Year		2b. HOUR 1:20 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1-13-00		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Millersville	
14. FATHER'S NAME First Middle Last ?		15. MOTHER'S MAIDEN NAME First Middle Last ?		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Margaret Scott Address Abner	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Pulmonary Emboli? DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASD DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Myocardial Infarction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10/18/69, to 1/25/69, that (I) (we) last saw the deceased alive on 1/24/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE J.B. Blawie MD		22c. DATE SIGNED 1/25/69		22d. PHYSICIAN'S NAME (Type) J.B. BLAWIE MD	
22e. ADDRESS 325 Hospital Dr. Glen Burnie Md 21061		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-28-69		23c. NAME OF CEMETERY OR CREMATORY Lanham Park	
23d. LOCATION (City or Town) (County) (State) Woodlawn Bethesda Md		23e. REC'D BY REGISTRAR JAN 28 1969		23f. REGISTRAR'S SIGNATURE	

10135



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00157

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00156

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Freeman				Gault	Month 1 Day 5 Year 69		10:30 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	Negro		10/14/24		44 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
South Carolina		USA				Anne Arundel Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Crownsville		Crownsville State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Balto		Baltimore				1706 Darley Avenue
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Daniel				Gault	Bessie			West
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
no				215-14-8538		Hospital Records, Crownsville State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia -</u>								
303.2 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>mal nutrition</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>chronic alcoholism -</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>68</u> , to <u>1-5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Alberto Gonzalez</u>								12/5/69
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Alberto Gonzalez, M.D.				Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		1-9-69		Mt. Calvary		A. A. County, Md.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<u>Joseph B. Locks</u>				<u>1304 N. Central</u>		JAN 7 1969		<u>James Judge</u>

00125

RECEIVED OF U.S. AIR FORCE

00125



JAN 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) George First LEROY GIBSON Middle LEROY GIBSON Last						2a. DATE OF DEATH January 14 1969 Month 1 Day 14 Year 1969			2b. HOUR 6:10 A			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH October 21 1911		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10. CITY OR TOWN OF DEATH Crooksville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crooksville State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 33 South Bond St		
14. FATHER'S NAME Saloma A. Gibson First Saloma A. Middle Gibson Last				15. MOTHER'S MAIDEN NAME Virginia Jackson First Virginia Middle Jackson Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. 579-16-9283		17. INFORMANT Medical Records - Crooksville State Hospital Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Old Myocardial Infarction; Old CVA; Pyelonephritis; Epilepsy												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 9/11 , 1964, to 1/14 , 1969, that (I) (we) last saw the deceased alive on 1/11 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.												
22b. SIGNATURE Lois McHenry Mapp DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1/14/69						
22d. PHYSICIAN'S NAME (Type) Lois McHenry Mapp						22e. ADDRESS Crooksville State Hospital Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY EBENEZER				23d. LOCATION (City or Town) (County) (State) Middleburg Fauquier, VA				
24. FUNERAL DIRECTOR James W Moser Fun. Home				ADDRESS WARRENTON, VA.				25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE William Judge		

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 00159 CERTIFICATE OF DEATH 00158 </div>											
1. DECEASED-NAME (Type or print) THOMAS			First H. Middle H. Last GOODE			2a. DATE OF DEATH JAN Month 12 Day 1969 Year			2b. HOUR 2:15 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 17 Dec 1926			6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Ft Geo G. Meade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Officer			12b. KIND OF BUSINESS OR INDUSTRY U.S.ARMY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 526 Maple Ridge Lane		
14. FATHER'S NAME First John Middle H. Last Goode, Sr.			15. MOTHER'S MAIDEN NAME First Lollie Middle Seldon Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give year or dates of service) 1945 - 1965			16b. SOCIAL SECURITY NO. 225-28-8639		17. INFORMANT (wife) Address Odenton, Md. Mrs. Rita Goode, 526 Maple Ridge Lane						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. POST NECROTIC CIRRHOSIS (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 Dec , 19 68 , to 12 Jan , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 Jan 19 69 , and that in (16) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Herbert Spolter</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 January 1969			
22d. PHYSICIAN'S NAME (Type) HERBERT SPOLTER, CPT, MC						22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/15/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Raymond C. Fink						Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

00158

00158

General
Navy and a Frank Olsen
Armed Forces
Armed Forces
Armed Forces

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00160									
00159									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Marie			First Middle Last O Grimes			2a. DATE OF DEATH Jan. Month 28 Day 69 Year			2b. HOUR 6:45 P
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-30-94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress (ret.)		12b. KIND OF BUSINESS OR INDUSTRY Garment Ind.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 2 Box 416	
14. FATHER'S NAME First Middle Last Patrick O'Connell			15. MOTHER'S MAIDEN NAME First Middle Last Mary Grimes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 213-05-0263		17. INFORMANT Address Mr. Lewis A. Grimes (son) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia, Bilateral									
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CARCINOMA Breast Ben									
DUE TO, OR AS A CONSEQUENCE OF (c) Post Operative Incarcerated Hernia 7 days.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION 1-22-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hernia, Inguinal, Strang. (R)		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-25-69, 19 to 1-28-69, 19 that (I) (we) last saw the deceased alive on 1-28-69, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. R. MacDonald M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-28-69			
22d. PHYSICIAN'S NAME (Type) C. R. MacDonald M.D.		22e. ADDRESS 325 Hospital Dr. Glen Burnie, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Boring, Balto. Co., Md.			
24. FUNERAL DIRECTOR E. B. Fleming		ADDRESS Singleton Funeral Home Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 31 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

00150

00150

00150



00161

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00160

1. DECEASED-NAME (Type or print) First Middle Last George Austin GUTHRIE			2a. DATE OF DEATH Month Day Year January 9, 1969		2b. HOUR A.M. or P.M. 7:15 M
3. SEX M	4. RACE W	5. DATE OF BIRTH 3-9-1916	6. AGE (In years lost birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel County Md.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.H. GENERAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CIVIL SERVICE	12b. KIND OF BUSINESS OR INDUSTRY RET.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 113 GREAT OAK DR.	
14. FATHER'S NAME First Middle Last FERRIS L. GUTHRIE	15. MOTHER'S MAIDEN NAME First Middle Last MARY V. ADAMS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) YES WW II	16b. SOCIAL SECURITY NO. 4121	17. INFORMANT Address CATHERINE G. GUTHRIE #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyper-tensive - arteriosclerotic cardiovascular disease 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/8, 1968 to 12/10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. I. Hochman, M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1/9/69	
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M. D.		22e. ADDRESS 16 Murray Avenue, Annapolis, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-11-69	23c. NAME OF CEMETERY OR CREMATORY HILLCREST	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.		
24. FUNERAL DIRECTOR John M. Loxton		ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR DATE JAN 14 1969	25b. REGISTRAR'S SIGNATURE James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DATE OF BIRTH

OUTSIDE

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And Animal Control

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11-20-11, Thursday, 11:00 AM

11-20-11, Thursday, 11:00 AM

11-20-11, Thursday, 11:00 AM

11-20-11, Thursday, 11:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

00162		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00161	
Item 7 Film 409 2/13/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) ROBERT L HALL			2a. DATE OF DEATH Month 1 Day 30 Year 1969		2b. HOUR 6:20 AM
3. SEX MALE	4. RACE Negro		5. DATE OF BIRTH April 1915		6. AGE (In years last birthday) 53 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. County, Glen Burnie Md.
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done last of working life, even if retired.) Rd	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Quarterfield & Queens Town
14. FATHER'S NAME First William Middle L Last Hall			15. MOTHER'S MAIDEN NAME First William Middle L Last Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cute coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) virus pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Obesity					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden about 20 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969 , to Jan 30, 1969 , that (I) (we) last saw the deceased alive on Jan 30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul J. Chang MD		22c. DATE SIGNED 1/30/69		22d. PHYSICIAN'S NAME (Type) Dr. Paul Chang	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 1-3-69		23c. NAME OF CEMETERY OR CREMATORY Bethel Nat. C.	
23d. LOCATION (City or Town) Bethel		23e. ADDRESS 801 Cain Hwy 58 Glen Burnie, Md		23f. COUNTY 2nd	
24. FUNERAL DIRECTOR E.O. Williams 1000 Remedy Dr.		25a. REC'D BY REGISTRAR DATE FEB 5 1969		25b. REGISTRAR'S SIGNATURE J. J. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00163		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00162					
Item 6 Film 408 1/23/69 kk						CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR			
ANNIE			MAY			Jan 19 1969			1148 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Fem		White		October 4, 1896		72 7/8 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Maryland		U.S.A.				Anne Arundel					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		North Arundel Genl Hosp		Operator		Box Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		13f. CITY OR TOWN	
Maryland		Anne Arundel		Pasadena				1898 Cedar Rd.		Pasadena Md.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		
Charles T. Eslein			Mary E. Callender			No					
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Mrs. Mary Dillard 405 Stately Dr. Pasadena			left ventricular failure			hours					
			DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial Infarction			hours					
			DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus			years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			Generalized Atherosclerosis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 20 1968, to Jan 19 1969, that (I) (we) last saw the deceased alive on Jan 19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS							
MAX C FRANK MD		415 SE Ritchie Hwy - Glen Burnie MD									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/23/69		Cedar Hill		Ritchie Highway A. A. Co. Md					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
McCully Fitt		237 Patapsco Ave. 21225		JAN 21 1969							

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Item 586 correct F41m4109 2/10/69 kk 00164		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00163	
1. DECEASED-NAME (Type or print) First Middle Last Rosie I Hamilton				2a. DATE OF DEATH Month Day Year 1 27 69	
3. SEX Female		4. RACE Colored American		5. DATE OF BIRTH 5/10/1899	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3 C. Ck Terrace		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Q. C. Anns.		13c. STREET AND NUMBER 3 C. Ck Terrace	
14. FATHER'S NAME First Middle Last William Wright		15. MOTHER'S MAIDEN NAME First Middle Last Charlotte Harrod		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no) or unknown) 170	
16b. SOCIAL SECURITY NO. 216342941D		17. INFORMANT Charlotte Hayden - Anns. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150 X	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months			
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 27 , 19 68 , to Jan. 27 , 19 69 , that (I) (we) last saw the deceased alive on Jan. 27 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. L. Richardson		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan. 28, 1969	
22d. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.		22e. ADDRESS 110 Clay St., Annapolis, Md., 21401			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/30/69		23c. NAME OF CEMETERY OR CREMATORY Annapolis Natl. Cemetery	
23d. LOCATION (City or Town) (County) (State) Annapolis Q.C. Md.		23e. REC'D BY REGISTRAR William Reese, Jr. - Anns. Md.		23f. REGISTRAR'S SIGNATURE Charles Judge	
23g. DATE JAN 29 1969					

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) JOE NMN HENSON						2a. DATE OF DEATH Jan. Month 19 Day 69 Year			2b. HOUR M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Feb. 11, 1897			6. AGE (In years birth day) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1159 Eastport Terrace			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1159 Eastport Terrace		
14. FATHER'S NAME First Benjamin Middle NMN Last Henson				15. MOTHER'S MAIDEN NAME First Louise Middle NMN Last Boone							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-05-0680		17. INFORMANT Annapolis, Md. Address Terrace Margaret or Magurite Henson-1159 Eastport						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 DAYS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GOVT											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from 1 AUG , 19 66 , to 19 JAN , 19 69 , that (1) (we) last saw the deceased alive on 15 JAN , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward S. Beck DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1-21-69					
22d. PHYSICIAN'S NAME (Type) Edward S. Beck Md						22e. ADDRESS 73 Franklin Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 24-69		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland					
24. FUNERAL DIRECTOR ADDRESS C.E. HICKS 111 Annapolis, Maryland						25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 11
304M REV 1/68

00166										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00165																																																																					
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																																					
First JOHN										Middle P.										Last HICKMON										JAN										Month 25										Day 1969										Year										8:20										M									
3. SEX Male										4. RACE White										5. DATE OF BIRTH April 3, 1947										6. AGE (In years last birthday) 22										YRS.										IF UNDER 1 YEAR MONTHS										DAYS										IF UNDER 24 HRS. HOURS										MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel										Md.																																																	
10. CITY OR TOWN OF DEATH Fort Geo G. Meade										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Serviceman										12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Reisterstown										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER Cockeys Mill Road																																																	
14. FATHER'S NAME First William Middle Last Hickmon										15. MOTHER'S MAIDEN NAME First Martha Middle Last Merkel																																																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes										(If yes give year or dates of service) 1966 - 1969										16b. SOCIAL SECURITY NO. 214-50-3046										17. INFORMANT 201 File, Dover Air Force Base, Delaware										Address																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 814.7 Laceration of thoracic aorta with hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF (b) Trauma after struck by automobile DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours										2 hours																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple fractures both lower legs, ribs, sternum & small subarachnoid hemorrhage																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work										21b. TIME OF INJURY HOUR A.M. Month Day Year 6:35M Jan 25 1969										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hit by auto while hitching																																																																					
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work										21e. LOCATION Street or R.F.D. No. City or Town County State Rt 695 & 170 (EBL of Rt 695) A.A.																																																																															
22a. I certify that (I) (this hospital) attended the deceased from 25 Jan, 1969, to 25 Jan, 1969, that (I) (we) lost saw the deceased alive on 25 Jan 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																																									
22b. SIGNATURE Frederick Shuster										22c. DATE SIGNED 25 Jan 1969										22d. PHYSICIAN'S NAME (Type) FREDERICK SHUSTER, CPT, MC										22e. ADDRESS US KIMBROUGH ARMY HOSP, FT MEADE, MD																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 28, 69										23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist										23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.																																																											
24. FUNERAL DIRECTOR J.F. ELINE & SON, 10 MAIN ST. REISTERSTOWN, MD										25a. REC'D BY REGISTRAR DATE FEB Jan 6 1969										25b. REGISTRAR'S SIGNATURE ORACE W. Jones MAJ																																																																					

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DEPARTMENT OF DEFENSE

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DOX-10104-6723-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #6, Film G408 1/20/69 AM
Item #13c, dFilm G408 1/20/69 km
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
00166
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Margaret		First Margaret Middle Highland Last Highland		2a. DATE OF DEATH Month 1 Day 8 Year 69		2b. HOUR 9:50p M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/29/1895		6. AGE (In years last birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvanian		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 122 Market Street		14. FATHER'S NAME First Emory Middle Sneads Last unknown		15. MOTHER'S MAIDEN NAME First unknown Middle unknown Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Hospital Records, Crownsville State Hosp.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerulonephritis 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus mal nutrition							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 68 , to 1-8 , 19 69 , that (I) (we) last saw the deceased alive on 1-8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alberto Gonzalez		22c. DATE SIGNED 1-9-69		22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez			
22e. ADDRESS 695 Americana Drive Annapolis		22f. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/13/69		23c. NAME OF CEMETERY OR CREMATORY National cemetery		23d. LOCATION (City or Town) (County) (State) Gottsburg, Adams Co., Pa.	
24. FUNERAL DIRECTOR Robert M. M...		25a. REC'D BY REGISTRAR 13 1969		25b. REGISTRAR'S SIGNATURE James J. Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00168										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00167									
Item #6, Film GL09 2/3/69 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Lost					2a. DATE OF DEATH Month Day Year					2b. HOUR M														
Catherine					Holtzer					1 16 69																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
female			White			11/25/01			68 67 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			US						Anne Arundel Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Crownsville			Crownsville State Hospital			housewife																							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Balto			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			1100 N. Calvert Street																	
14. FATHER'S NAME First Middle Lost					15. MOTHER'S MAIDEN NAME First Middle Lost																								
unknown					unknown																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
no					213-12-2529T					Hospital Records, Crownsville State Hospital																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism -</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus -</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-5</u> , 19 <u>68</u> , to <u>1-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Alberto Gonzalez</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 1/16/69																			
22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez</u>					22e. ADDRESS <u>695 Americana Dr. 24 - Annapolis</u>																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <u>1-25-69</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>					23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>														
24. FUNERAL DIRECTOR ADDRESS <u>John C. Miller Inc-6415 Belair Rd.-21206</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 29 1969</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			

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UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

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10 JUL 1964

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
MARIE Z. HOLZINGER						Month Day Year			1 5 49 P
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
F	W	12/18/1891	77 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	1 5 49 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Hungary		U.S.A.				Anne Arundel Co. Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie			NORTH ARUNDEL			Retired Grocery			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Anne Arundel			Ferndale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
Anton Zietvogel			Elizabeth Prinz			110 Wells Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
			220-30-4959		Mrs. Anna H. Sisolak, 112 Wells Avenue 21061				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4299 Heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D.			1-6-69			
E. Linhart						RACS.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Md.			
BURIAL		1-9-1969		Glen Haven Cemetery		Glen Burnie, Anne Arundel County			
24. FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave. 21229						JAN 8 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VERIFIED
JAN 15 1968

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
00170											
00169											
1. DECEASED-NAME (Type or print) First Middle Last			20. DATE OF DEATH			2b. HOUR					
Robert A Howell III			1-1-69			14 A M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		W		20 May 1926		42 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Virginia		U.S.A.				A.A.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			7878-Amerexa Circle			Inspector			- Gled		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD			A.A.						Americana apt.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Robert A. Howell-Jr			Emily Gardner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
yes			230-12-7634		Mrs. Helen E. Howell (wife)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Generalized Carcinoma of the										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Co. Cancer											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1963, 19, to 1969, 19, that (I) (we) last saw the deceased alive on 12-30-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert R. Hahn						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-1-69			
22d. PHYSICIAN'S NAME (Type) Robert R. HAHN						22e. ADDRESS P.O. Box 73 Severna Park					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6 Jan. 1969		Glen Burnie		Glen Burnie Md.					
24. FUNERAL DIRECTOR RV Singleton - Glen Burnie, Md.						25a. REC'D BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) JOSEPH C. HOWES			2a. DATE OF DEATH Month 1 Day 14 Year 69			2b. HOUR P			
3. SEX M		4. RACE W		5. DATE OF BIRTH 8-9-1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH ARNOLO		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT#2 Box 149		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) UMBER YARD		12b. KIND OF BUSINESS OR INDUSTRY RET.			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN ARNOLO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT#2 Box 149	
14. FATHER'S NAME First JOHN Middle DUVALL Last HOWES			15. MOTHER'S MAIDEN NAME First FLORENCE Middle WARD Last WARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214 050895		17. INFORMANT Dorothy D. HOWES		Address #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. , 19 68 , to Jan. 13 , 19 69 , that (I) (we) last saw the deceased alive on Jan. 13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Theodore G. De Gaetano				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-14-69	
22d. PHYSICIAN'S NAME (Type) Theodore G. De Gaetano				22e. ADDRESS Kitchie Hwy - Arnold - Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-17-69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis A.H. MD.			
24. FUNERAL DIRECTOR John M. Taylor & Sons				25a. REC'D BY REGISTRAR Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JAN 17 1969	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Edward			Hoy			Jan. 17 1969			7:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
M		W		Oct. 11, 1877		91 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Millersville		Knollwood N. H.		Machinist (ret.)		Gross Mech. Lab			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Glen Burnie				Sundown Rd. (Ferndale)	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John T. Hoy			Harriett Elsgood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			213 12 4205		Mr. Joseph Hoy (nephew) Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Concertive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF - (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ray M. Smith</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 18, 1969			
22d. PHYSICIAN'S NAME (Type) Ray M. Smith M. D.				22e. ADDRESS Hahn Professional Bldg., Severna Park, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 21/69		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR <u>R. L. Singleton</u>		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. REC'D BY REGISTRAR JAN 22 1969		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00173

00172

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1327 Howard Rd</u>				d. STREET ADDRESS <u>1327 Howard Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Leaman</u> Last <u>Huestis</u>				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1969</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/21/15</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>			
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
16. FATHER'S NAME <u>Hesse Leamon Huestis</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Blankenbeker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>577-07-1495</u>			
17. INFORMANT <u>Barry Marsden Huestis</u>				Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> <u>4109</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Basilar Artery Occlusion</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>5 mos.</u> <u>6 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>-</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> 19 <u>50</u> to <u>1/8</u> 19 <u>69</u> , that (I) <u>was</u> lost saw the deceased alive on <u>1/8</u> 19 <u>69</u> , and that death occurred on <u>1/16</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R.W. Prichard</u>				22b. DATE SIGNED <u>1/17/69</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>				22d. ADDRESS <u>Glen Burnie, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>Jan. 20, 1969</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>				23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Sangster</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>JAN 17 1969</u>			

MASSACHUSETTS STATE DEPARTMENT OF CORRECTIONS

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MASSACHUSETTS STATE DEPARTMENT OF CORRECTIONS

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STATE DEPARTMENT OF
CORRECTIONS

MASSACHUSETTS
STATE DEPARTMENT OF
CORRECTIONS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00174 CERTIFICATE OF DEATH 00173											
1. DECEASED NAME (Type or print)		First Frank		Middle E.		Last Hutchinson		2a. DATE OF DEATH Month 1/4 Day 89 Year		2b. HOUR 5:00	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 15, 1918		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HOURS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel					
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electric					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A. A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 7 Box 267			
14. FATHER'S NAME First Mason Middle Hutchinson Last				15. MOTHER'S MAIDEN NAME First Mattie Middle Hackett Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes # 2		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norma Hutchinson				Address Rt. 7 Box 267	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) ASHD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from DOA , 19____, to____, 19____, that (I) (we) last saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Dorkan		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-4-69	
22d. PHYSICIAN'S NAME (Type) C. Dorkan, M.D.		22e. ADDRESS 375 Hospital Drive, G. Burnie, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1 8 69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Brooklyn, A.A. Co. Md.					
24. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.		25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

01173

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DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbar papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00175					00174						
1. DECEASED-NAME (Type or print) First Middle Last LISA ANNETTE HUTCHINSON					2a. DATE OF DEATH JAN Month 6 Day 1969 Year			2b. HOUR 4:48p M			
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH Jan 5, 1969			6. AGE (In years last birthday) YRS. MONTHS DAYS 1		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Anne Arundel		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Ft Geo G. Meade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Landover		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3507 Dodge Pk Rd, Apt 202				
14. FATHER'S NAME First Middle Last Carl F. Hutchinson					15. MOTHER'S MAIDEN NAME First Middle Last Thelma Beliflower						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Address Landover, Md Carl F. Hutchinson, 3507 Dodge Pk Rd, Apt 202						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS SYNDROME</u> 7762 DUE TO, OR AS A CONSEQUENCE OF (b) <u>LOW BIRTH WEIGHT FOR GESTATIONAL AGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>69</u> , to <u>6 Jan</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>6 Jan</u> , 19 <u>69</u> , and that in (our) (aur) apinian death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William L. Weston MD</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 6 January 1969		
22d. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WESTON, CPT, MC,</u>						22e. ADDRESS <u>US KIMBROUGH ARMY HOSP, FT MEADE, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/8/69		23c. NAME OF CEMETERY OR CREMATORY Garden of Memory, Fla			23d. LOCATION (City or Town) (County) (State) Florence, South Carolina			
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke Ellicott City, Md.						25a. REC'D BY REGISTRAR DATE JAN 8 1969			25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 4-64
30M REV. 1-48

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00176 00175											
Item #11&13e, Film G409 2/3/69 km CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last William Matthew Johnson						2a. DATE OF DEATH Month Day Year January 21, 1969			2b. HOUR 7 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-13-1875		6. AGE (In years last birthday) 93 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Tracy's Landing		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #2-Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Tracy's		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER none			
14. FATHER'S NAME First Middle Last Uriah Johnson				15. MOTHER'S MAIDEN NAME First Middle Last Alice Mayhew							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-54-4888		17. INFORMANT (Son) Address James W. Johnson Tracy's Landing							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1969 , to Jan 21, 1969 , that (I) (we) last saw the deceased alive on Jan 21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Willard F. Smith		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-22-69					
22d. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22e. ADDRESS Shady Side, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/24/69		23c. NAME OF CEMETERY OR CREMATORY St James Episcopal		23d. LOCATION (City or Town) (County) (State) Lothian, Md					
24. FUNERAL DIRECTOR Hutchins Funeral Home,		ADDRESS Owings, Md.		25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

THE COURT OF COMMONS, IN SENATE, AT THE CITY OF NEW YORK, ON THE 10TH DAY OF JANUARY, 1900.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, JANUARY 10, 1900.

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS, 1900.

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FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00177

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00176

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b. HOUR		
CLARENCE P. JONES						1 12 189				5:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR
Male	White	3/4/1893	75 ? YRS.					January 12 1969				5:30 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Cintra, Va.		U. S. A.				Anne Arundel Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie Annapolis		Dorsey Rd. (back of 1913-)				Operator			Plastic			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.				A. A.		Glen Burnie Annapolis				Back of 1913 Dorsey Rd.		
14. FATHER'S NAME First Middle Lost				15. MOTHER'S MAIDEN NAME First Middle Lost								
Charles Henry Jones				Elizabeth Catherine Lampkin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
Yes				World War 1		229-14-2425 William W. Owens 163 Whitney Landing						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				Edward F. Wilson, M.D.				22b. DATE SIGNED 1/13/69				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial				1/16/1969		Baltimore National		Baltimore, Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Raymond C. Fink Glen Burnie, Md.						JAN 16 1969		[Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00178		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00177	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
Grace				Jones	Month	Day	Year
					1	5	1969
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Negro		2/??/1903		66? YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Unknown		Unknown				Anne Arundel Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		D.C. Children's Center Hospital		Institutionalized			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET AND NUMBER	
Unknown		Unknown		Unknown		Unknown	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First Middle Lost
Unknown					Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Children's Center Hospital,		Laurel, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 486X		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Aspiration of Gastric Contents.					
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/25/49 to 1/5/69, that (I) (we) last saw the deceased alive on 1/5/69 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
Rolando V. Goco, M.D.		1-6-69		Rolando V. Goco, M.D.		Children's Center Hospital Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
1/9/69		Children's Center		Laurel		AACA Md	
24. FUNERAL DIRECTOR		ADDRESS		25. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donaldson Funeral Home		Laurel Md.		JAN 13 1969		JAN 13 1969	

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CONCLUSIONS

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2070-11-11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

00179

00178

1. DECEASED-NAME (Type or Print) IRA		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR															
						JONES										PM															
3. SEX M		4. RACE W		5. DATE OF BIRTH 12-27-12		6. AGE (In years lost, birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month 1 Day 24 Year 1969				2d. HOUR PM															
7a. BIRTHPLACE (State or foreign country) W. VA.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH A.A. CO.				Md.															
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 104 North Arundel				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINT.				12b. KIND OF BUSINESS OR INDUSTRY UTILITIES																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY A.A.				13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 416 Ritchie Hwy.																	
14. FATHER'S NAME JAMES				First				Middle				Last				15. MOTHER'S MAIDEN NAME ADA				First				Middle				Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				(If yes give war and dates of service) II				16b. SOCIAL SECURITY NO. 233 07-7138				17. INFORMANT Mrs. Margaret Jones				ADDRESS As Above															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis generalized 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																															
ACTUAL SIGNATURE E. Linhardt						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 1-24-69																			
EXAMINER'S NAME (Type) E. Linhardt						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
						ADDRESS (Street, city, town, or county) P.A. CO.																									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/29/69				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia																			
24. FUNERAL DIRECTOR Raymond C. Fink								ADDRESS Glen Burnie, Md.				25a. REC'D BY REGISTRAR DATE JAN 29 1969				25b. REGISTRAR'S SIGNATURE Charles Judge															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Published by the American Medical Association, 535 N. Dearborn Ave., Chicago 10, Ill.

Raymond C. Pink Glen Burnie, Md. 144 10 1982 144 10 1982

CERTIFICATE OF DEATH

00180

00179

1. DECEASED-NAME (Type or print) Essie First G. Middle Jump Last			2a. DATE OF DEATH Month JANUARY Day 6 Year 1969			2b. HOUR 5⁰⁰ A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 24, 1885		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.	
10. CITY OR TOWN OF DEATH Glen Burnie MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Conv. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY Anne Arundel		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First — Middle — Last SELF		15. MOTHER'S MAIDEN NAME First MARTHA Middle JONES Last —		17. INFORMANT Woodrow S. Harrison Address 46 Boone Trail Severna Park, Md			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown — (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. —		17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF 4124 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov 18, 1968 , to Jan 5, 1969 , that (I) (we) lost saw the deceased alive on Jan 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jochi I. Stern		22c. DATE SIGNED 1/6/69		22d. PHYSICIAN'S NAME (Type) Jochi I. Stern			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE Jan 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Oliver Cemetery		23d. LOCATION (City or Town) (County) (State) St. Michaels Talbot Md	
24. FUNERAL DIRECTOR Harrison E. Leonard		25a. REC'D BY REGISTRAR 14 N 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00112

OFFICE OF THE

10100

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]

FOR STATE HEALTH DEPT.

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00181

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00180

1. DECEASED-NAME (Type or Print) HERMAN K. JUPITZ			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 1 9 19 69 9:10			2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 21, 1926	6. AGE (In years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year January 9, 19 69 9:10
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stevenson		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A. A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Carl Jupitz		15. MOTHER'S MAIDEN NAME First Middle Last Anne Walk		13e. STREET AND NUMBER Box 83 F. Rt. 10 Pasadena, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16b. SOCIAL SECURITY NO. 214-20-4306		17. INFORMANT ADDRESS Mrs. Pauline Jupitz Route 10 Box 83 F Pasadena, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Isopropyl Alcohol intoxication 8539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 1 6 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject ingested isopropyl alcohol		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Box 83 Rt. 10 Pasadena A. A. Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Edward F. Wilson		M.D. Edward F. Wilson, M.D.		22b. DATE SIGNED 1/9/69		
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue				25a. REC'D BY REGISTRAR DATE JAN 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

00180

RECEIVED

1954

FOR STAFF

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C. 20315



100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

JAN 14 1954

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00182		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00181			
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR P M	
PETER EDWARD KAIROS						JANUARY 21 1969		1:22	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		DECEMBER 17, 1926		42 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		USA				ANNE ARUNDEL			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL GENERAL		UPHOLSTERER		UPHOLSTERY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTO.		BALTIMORE				884 MILDRED AVE	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
GEORGE KAIROS						VIOLET STANELY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			220 20 5956		DEBORA E. KAIROS (wife)		SAME AS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) A. S. C. V. D.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from Jan 19, 1969, to Jan 21, 1969, that (1) (we) last saw the deceased alive on Jan 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Dabolins MD					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 21, 1969
22d. PHYSICIAN'S NAME (Type) ROBERT DABOLINS, MD					22e. ADDRESS 400 Chain Hwy NW Glen Burnie Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN. 24/69		GLEN HAVEN MEMORIAL PARK		GLEN BURNIE, MD.			
24. FUNERAL DIRECTOR R. Singleton		SINGLETON		FUNERAL HOME GLEN BURNIE, MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 23 1969		25b. REGISTRAR'S SIGNATURE R. Singleton	

18100

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00183 CERTIFICATE OF DEATH 00182											
1. DECEASED-NAME (Type or print) First Middle Last EDGAR LEE Keiter			2a. DATE OF DEATH Month Day Year January 6 1969			2b. HOUR 10:13 PM					
3. SEX MALE		4. RACE white		5. DATE OF BIRTH APRIL 14, 1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fore MAN		12b. KIND OF BUSINESS OR INDUSTRY Silk Mill					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN ODENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1610 Annapolis Rd			
14. FATHER'S NAME First Middle Last Frederick Theodore Keiter			15. MOTHER'S MAIDEN NAME First Middle Last Lucinda (unknown) CLARK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-07-4919		17. INFORMANT MRS. ANITA Keiter (wife) 1610 Annapolis Rd		Address Odenton Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CRUSHED L-1 VERTEBRAE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec 21, 1968, to Jan 6, 1969, that (we) last saw the deceased alive on Jan 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE T.C. Callis MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) T.C. Callis MD					22e. ADDRESS Hahn Professional Building Baltimore Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 9 1969		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION (City or Town) (County) (State) ELKridge Maryland					
24. FUNERAL DIRECTOR E.B. Fleming		ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD.		25a. REC'D BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE Charles Yager					

00182

CERTIFICATE OF DEATH

00182

(C) Mrs Anita Ketter of Waterbury

684
JAN 21ST MEADOWS MARK ELLIOTT
JAN 21ST 1908
JAN 21ST 1908
JAN 21ST 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.
Douglas Stokes KING						January 14 1969			1:15 M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Negro		Dec. 13, 1905			63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Connecticut		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel Gen. Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				Rt-3, Arundel on the Bay	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James V. King			Anna J. Noble						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Dorinda H. King Annapolis Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio Vascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 2 wks</u> <u>5 wks</u> <u>9 wks</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. T. Allen</u>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.					22e. ADDRESS 62 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-18-1969		23c. NAME OF CEMETERY OR CREMATORY Balding Hill Cem		23d. LOCATION (City or Town) (County) (State) Princess Anne Md			
24. FUNERAL DIRECTOR H.S. Washington & Son					25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film G-109

1/29/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
00185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00184

1. DECEASED-NAME (Type or Print)		First		Middle		Last		20. DATE KNOWN OF DEATH				2b. HOUR	
Howard		V.		King				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 1 17 1969				11:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	C	12/25/1915		53 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year 1 17 1969		11:55 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Balt. Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel		Carroll County				AM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Jessup		Md. House of Correction		Unemployed		None							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		Anne Arundel		—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		no permanent address					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
John		King		ETIA		Queen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				unk.		Helen Bailey		1215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>													
4109 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				Werner U. Spitz, M.D.				Assistant Medical Examiner <input checked="" type="checkbox"/> Deputy Medical Examiner <input type="checkbox"/>					
				ADDRESS (Street, city, town, or county)				Jan 18, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				1-12-69				M.T. Auburn					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
MORTON & DyeTT F.H. Inc.				1701 LAURENS				DATE JAN 20 1969					
								25b. REGISTRAR'S SIGNATURE					
								[Signature]					

00180

DOUGLAS AIRCRAFT COMPANY, INC. CHICAGO, ILL.

Bill H. H. H.

Bill H. H. H.

Bill H. H. H.

Bill H. H. H.



Bill H. H. H.

Bill H. H. H.

Bill H. H. H.

FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, Film #11 4/7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03325

1. DECEASED-NAME (Type or Print) Rev. First Middle Last C.S.S.R. THOMAS KOZLOVSKY			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1 13 69			2b. HOUR P	
3. SEX M	4. RACE W	5. DATE OF BIRTH 1/19/09	6. AGE (In years) 1607 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 30 Year 1969	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL CO	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WEEKS CREEK		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PHYSICIAN		12b. KIND OF BUSINESS OR OCCUPATION PHYSICIAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO. - BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Thomas Kozlovsky		15. MOTHER'S MAIDEN NAME First Middle Last Mary Kaspar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rev. Vincent Crotty, 2111 Ashland Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9109 Stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) First Farm		21f. LOCATION Street or R.F.D. No. City or Town County State Severn River - Annapolis			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. Linhardt		EXAMINER'S NAME (Type) E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/30/69 APCO	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/2/69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

24th Dec 1894

1/2/19

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00186		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00185				
1. DECEASED-NAME (Type or print) First Middle Last William Frederick Krahling						2a. DATE OF DEATH Month Day Year January 8, 1969		2b. HOUR M AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12/27/1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Balto. Co. Md		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Glen Burnie, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Genl Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Supervisor U. S. Coast Guard		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY 13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3808 4th Street 21225		
14. FATHER'S NAME First Middle Last Hertman Krahling		15. MOTHER'S MAIDEN NAME First Middle Last Johanna Niemann								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 217-34-5035		17. INFORMANT Address Mrs. Lillian M. Krahling 3808 4th St. 21225						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: 4109 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 65 , to 1/8 , 19 69 , that (I) (we) last saw the deceased alive on 1/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. M. McLaughlin					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/9/69			
22d. PHYSICIAN'S NAME (Type) R. M. McLaughlin					22e. ADDRESS 5208 Mountain Rd. Pasadena, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Ritchie Hwy Anne Arundel Co.				
24. FUNERAL DIRECTOR McCully F. H.					ADDRESS 237 Patapsco Ave. 21225		25a. RECEIVED BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE [Signature] Md.	

00182

IN REPLY TO MAIL

00182

COPIES

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00187

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00186

1. DECEASED-NAME (Type or Print) HERBERT Charles KULENEK			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year MATED <input type="checkbox"/> 1 30 69			2b. HOUR A M												
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-29-67		6. AGE (in years last birthday) 18 mo YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 1 30 1969			2d. HOUR A M						
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel, Md.									
10. CITY OR TOWN OF DEATH Glen Burnie						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md						13b. COUNTY A.A.						13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1708 Leisure Lane					
14. FATHER'S NAME Richard C Kulenek						First Middle Last						15. MOTHER'S MAIDEN NAME Catherine Smith						First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. None						17. INFORMANT Mr. Richard C. Kulenek, Riviera Beach, Md.						ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 5089 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Shunt							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE E. Linhardt						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 1.30.69 HACD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE 2/3/69.						23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery						23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						ADDRESS						25a. REC'D BY REGISTRAR JAN 31 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

00100

UNITED STATES DEPARTMENT OF JUSTICE

1937

FOR THE
RECORD

NAME	WIFE	DATE	1937-07-10	PLACE	NEW YORK
NAME	WIFE	DATE	1937-07-10	PLACE	NEW YORK

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

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NAME: [illegible] DATE: [illegible] PLACE: [illegible]

NAME: [illegible] DATE: [illegible] PLACE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00188											
00187											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) aka Ruth		Birth White		Middle Marie		Lost LEE		2a. DATE OF DEATH Month January Day 11 Year 1969		2b. HOUR A. 9:45 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 29, 1915		6. AGE (in years lost birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dead on arrival Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) payroll mach. operator		12b. KIND OF BUSINESS OR INDUSTRY City gov't					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 23 State Circle			
14. FATHER'S NAME First Joseph Middle White Lost		15. MOTHER'S MAIDEN NAME First Cenia Middle Gregg Lost									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 245-09-9833		17. INFORMANT Augustine J. Lee - same as #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 571.9 (b) HEPATIC CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6-20, 1936 to 1-11, 1969 , that (I) (we) last saw the deceased alive on 1-11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward S. Beck MD		22c. DATE SIGNED 1-11-69		22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.							
22e. ADDRESS 73 Franklin St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/14/69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.					
24. FUNERAL DIRECTOR Key E. Hopping		ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.		25. RECD BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00189		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00188			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First Middle Last EVA NMN LEGUM						1 Month 11 Day 69 Year		3 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Cauc.		8-7-88		80 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Poland		USA				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		A.A. General Hospital		never worked					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				109 Lafayette Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Joseph		Goldberg		Anna Fishman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
no		217-14-5890		Donald Levy 2225 Richland Drive, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> 2079 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-21, 1968, to 1-11, 1969, that (I) (we) last saw the deceased alive on 1-11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Adeleke Adeyemo				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 1-11-69	
22d. PHYSICIAN'S NAME (Type) ADELEKE ADEYEMO				22e. ADDRESS ANNAPOIS, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/12/69		Kneseth Israel Cemetery		Annapolis, Md.			
24. FUNERAL DIRECTOR E. Hopping				ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE	

881014

ESTIMATE OF DEATH

881014

LEUKEMIA

CA A

Chetkin, Eugene
Roe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00190

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00189

1. DECEASED-NAME (Type or print) First Middle Last Carroll R. Logue			2a. DATE OF DEATH Month Day Year Jan. 14 1969		2b. HOUR 12:50AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 3, 1900		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Carroll Co., Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel		Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machinist (ret.)	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER Box 400, Manhattan Bch. Rd.					
14. FATHER'S NAME First Middle Last James A. Logue		15. MOTHER'S MAIDEN NAME First Middle Last Rosie A. Collins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. WW I & II 219-28-5460		17. INFORMANT Address Box #20 Mr. Paul C. Louge (brother) Millersville,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Idiosyncratic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① Diabetes mellitus ② arthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ray M. Smith, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 1/14/69					
22d. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22e. ADDRESS Hahn Professional Bldg., Severna Pk., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 17 1969		23c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery	
23d. LOCATION (City or Town) (County) (State) Warfieldsborg, Maryland					
24. FUNERAL DIRECTOR E.B. Hemeny		ADDRESS Singleton Funeral Home, Glen Burnie, Md.		25a. RECD BY REGISTRAR JAN 17 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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Dr. Hilary O'Herlihy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 409 1-24-69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00191					00190					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
Grace I. Lower					1 Month 6 Day 1969			10:50 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		W		5-18-11		57 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Anne Arundel Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			No. Arundel Hospital			Housework		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Glen Burnie				7819 Oakwood Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Basil Johnson			(unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			220 10 7660		Mr. Carl A. Lower (husband) Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Repeate Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30-</u> , 19 <u>62</u> , to <u>1-6-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-6-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Hilary O'Herlihy</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22c. DATE SIGNED <u>1-7-69</u>										
22d. PHYSICIAN'S NAME (Type) <u>Hilary O'Herlihy</u>										
22e. ADDRESS <u>Oakwood Rd. Glen Burnie, Md.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)										
23b. DATE <u>Jan. 10, 1969</u>										
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>										
23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>										
24. FUNERAL DIRECTOR <u>R. J. Singello</u> <u>Singleton General Home</u> <u>Glen Burnie, Maryland</u>										
25a. REC'D BY REGISTRAR <u>J. N. 13</u> <u>1969</u>										
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>										

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

00181

CERTIFICATE OF DEATH

1953

JANUARY 1, 1953

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00193

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00192

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR							
Vernon						Martin		ESTIMATED <input checked="" type="checkbox"/>		1		5		69		A M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR			
M		W		9/11/20		48 YRS.		MONTHS		DAYS		HOURS		MIN.		Jan.		5		1969		1:10a	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH											
Md.				U.S.								Anne Arundel											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Glen Burnie				North Arundel																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER							
Md.				Anne Arundel				Glen Burnie				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				280 Eleventh St.							
14. FATHER'S NAME				First				Middle				Last				15. MOTHER'S MAIDEN NAME							
				?												?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
no				218-01-7076				Evelyn L. Martin				280 11th. St. Chelsea Beach											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u>																18 YRS.							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
MEDICAL CERTIFICATION																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
						HOUR A.M. P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>E. Linhardt</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED											
EXAMINER'S NAME (Type) <u>E. Linhardt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						1-5-69											
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						HAC											
						ADDRESS (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)					
Burial						1/8/69						Pine Grove Balto. Co.						Balto. Co.					
24. FUNERAL DIRECTOR																							
Paul E. Chenoweth Jr. 3617 Chestnut Ave.																							
25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
DATE JAN 10 1969												<u>Charles Judge</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
45M - 1/69

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Louise Theresa MASSCRO					Month	Day	Year	P. M.	
January 20 1969		8:42							
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White		May 21, 1915		53 YRS.		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		111 Edelmarr Drive	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Salvatore Battaglia					Rosario Cascio				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		219-28-7692		Carmello Masscro		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 hour</u> <u>2 hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic cardiovascular disease, coronary & general; diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NA				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19</u> , 19 <u>68</u> , to <u>January 20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>January 10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<u>Charles W. Kinzer</u>		January 21, 1969		Charles W. Kinzer, M. D.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR	
Burial		1/24/69		New Cathedral		Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE	
								J. Charles Judge	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland				DATE JAN 22 1969					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00195

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00194

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Alice Maynard			2a. DATE OF DEATH Month 1 Day 15 Year 69			2b. HOUR 9A M					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 3/23/1888		6. AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Tracy Landing			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Tracy Landing			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY A.A.		13c. CITY OR TOWN Tracy Landing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First William Middle Creek Last 			15. MOTHER'S MAIDEN NAME First Christanna Middle Hall Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 220-56-1235		17. INFORMANT Address Margaret E. Gross Tracy Landing, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Also had diabetes mellitus											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No injury							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 		21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from 1945 to 1/14 , 19 69 , that (I) (we) last saw the deceased alive on 1/14/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles H. Wirth M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/15/69					
22d. PHYSICIAN'S NAME (Type) CHARLES H. WIRTH, M.D.				22e. ADDRESS LOTHIAN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) 		23b. DATE JAN. 18-69		23c. NAME OF CEMETERY OR CREMATORY Tr. Carters Church Cem		23d. LOCATION (City or Town) (County) (State) Friend Ship. A.A. Md					
24. FUNERAL DIRECTOR Penney E. Seewell, Prince Georges				ADDRESS 		25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE del. m. C. C. C.			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00196

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00195

1. DECEASED-NAME (Type or Print) <i>Joseph F McCarthy</i>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <i>1</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>P</i> M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>12/7/26</i>	6. AGE (in years last birthday) <i>42</i> YRS.	IF UNDER 1 YEAR MONTHS OAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>18</i> Year <i>1969</i>			2d. HOUR <i>P</i> M
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>DOA-NORTH ARUNDEL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>			13b. COUNTY <i>A.P. Co. Pasadena</i>		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>mt. Leans wicks Lane</i>		
14. FATHER'S NAME <i>Robert J. McCarthy</i>			15. MOTHER'S MAIDEN NAME <i>MARY E. STUART</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>578-28-8853</i>		17. INFORMANT <i>MARY C. MCCARTHY - (mother)</i> ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4122</i> (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Thrombosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>1-15-69</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)			<i>AACO</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/22/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial Park</i>		23d. LOCATION (City or Town) <i>Elkridge</i>		(County)	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Robert Leary</i>			ADDRESS <i>Sing Leary Funeral Home - Glen Burnie Md.</i>			25a. REC'D BY REGISTRAR <i>JAN 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>	

00123

REPORT OF THE BOARD OF HEALTH

00123

REPORT OF THE BOARD OF HEALTH



REPORT OF THE BOARD OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Virgie			Lee			McGUIRE		January 2 1969 4:00 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Oct. 31, 1926		42 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Baltimore				7818 Bridge Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John D. Simmons			Virginia Horner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no						David J. McGuire, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Statue Asthmatic</i> 471X DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d 1726 four hr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Asthma</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-31, 1968</i> , to <i>1-2, 1969</i> , that (I) (we) last saw the deceased alive on <i>1-1-69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frank Murphy MD.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-2-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>F M SHIPLEY</i>				22e. ADDRESS <i>121 Cathedral St., Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6 Jan. 69		Glen Haven Memorial		Glen Burnie, Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Kirkley Funeral Home, Glen Burnie, Md.				JAN 6 1969		<i>[Signature]</i>			

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David J. Little, owner and 19

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Let's talk about it 10:50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 134
30M RE 1/66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00198									
CERTIFICATE OF DEATH									
00197									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Catherine			McMillian			Month 1 Day 16 Year 69			1:40p
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		1879		90 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
South Carolina		US				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Crownsville		Crownsville State Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Balto		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3407 Homes Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Henry Miller unknown			Axie unknown Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			none		Hospital Records, Crownsville State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis - emphysematous</u> <u>595X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhagic cystitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>A.S.U.D. 8 Extreme mal nutrition</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/</u> , 19 <u>59</u> , to <u>1/16</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>1/16/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alberto Gonzalez</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez</u>					22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan 21, 1969		Mt. Auburn Cem. Bk No. Md.					
24. FUNERAL DIRECTOR <u>Williams Funeral Home 3197 Schrock St</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>		

52100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00199		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00198			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First MARVIN		Middle -		Last MEADOWS		2a. DATE OF DEATH 1 Month 30 Day Year 69 10 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-26-24 1923		6. AGE (In years lost birthday) XXX 45 RS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Glen Burnie		Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard		12b. KIND OF BUSINESS OR INDUSTRY Dennis Detect			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 24	
14. FATHER'S NAME First Middle Last Elmer Meadows		15. MOTHER'S MAIDEN NAME First Middle Last Lucinda Wood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No None		16b. SOCIAL SECURITY NO. 217-16-2193		17. INFORMANT Loretta Address Mrs. M. Meadows (wife) Same as #1					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 1978 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral regurgitation bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of the liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours days year.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 69 , to 1/30 69 , that (I) (we) last saw the deceased alive on 1/30 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Frank		22c. DATE SIGNED 1/30/69		22d. PHYSICIAN'S NAME (Type) Dr. Frank					
22e. ADDRESS 425 SE Ardmore Hwy - Glen Burnie, Md 21061									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland			
24. FUNERAL DIRECTOR E.B. Thompson		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR Feb 3 1969		25b. REGISTRAR'S SIGNATURE James Judge			

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00200		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00199	
Item 5 Film G408 1/15/69 kk							
1. DECEASED-NAME (Type or print) Pansy Violet Merryman				2a. DATE OF DEATH 1 Month 8 Day 69 Year		2b. HOUR 12:40A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-11-89 1890		6. AGE (In years lost birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 104 Ridge Ave.		14. FATHER'S NAME First Middle Last Martin H.K. Paulsen		15. MOTHER'S MAIDEN NAME First Middle Last Blanche A Marsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Blanche Albough		Address Rhesville 8, Md. Hawthorne Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of bladder carcinoma 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA old, HASCVD, Decubitus ulcers							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-25-1969 , to 1-8-1969 , that (I) (we) last saw the deceased alive on 1-8-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. S. Dorkan		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-8-69	
22d. PHYSICIAN'S NAME (Type) Cenap S. Dorkan M.D.		22e. ADDRESS 325 Hospital Drive, G. Burnie					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Trinity Ridge Burial		23d. LOCATION (City or Town) (County) (State) Rhesville Baltimore Md.	
24. FUNERAL DIRECTOR Frank H. Newell		ADDRESS Rhesville, Md.		25a. REC'D BY REGISTRAR Jan 13 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00200																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										P. M.																																							
Alice Rairdon MITCHELL										January 13 1969										2:50																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										June 20, 1905										63 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Jew Jersey										U.S.																				Anne Arundel																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Annapolis										Anne Arundel Gen. Hospital										Housewife										Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Anne Arundel										Annapolis										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										Rt-3, Wild Shores																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
JOSEPH Rairdon										LAURA CLAFFY																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										214 32873										William C Mitchell										#13																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH CAUSED BY:																																																											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										3 HOURS																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) CORONARY THROMBOSIS										3 HOURS																																							
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
BRONCHIECTASIS, BRONCHOPNEUMONIA																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (u) (this hospital) attended the deceased from June, 1959, to 13 Jan, 1969, that (u) (we) last saw the deceased alive on 13 Jan, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Edward S. Beck										1-14-69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Edward S. Beck, M.D.										73 Franklin St., Annapolis, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town), (County) (State)																													
Burial										1-16-69										St. Marys										Annapolis A.H. MD.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
John M. Lytle, Annapolis, Md.										JAN 16 1969										Charles Judge																																							

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CHARTER OF DEATHS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <i>Eugene Mitchell Jr.</i>			2a. DATE KNOWN OF DEATH Month <i>1</i> Day <i>22</i> Year <i>1969</i>			2b. HOUR <i>A M</i>				
3. SEX <i>M</i>	4. RACE <i>N</i>	5. DATE OF BIRTH <i>3/21-68</i>	6. AGE (In years last birthday) YRS. <i>10</i>	IF UNDER 1 YEAR MONTHS <i>10</i> DAYS	IF UNDER 24 HRS HOURS <i>10</i> MIN.	2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>22</i> Year <i>1969</i>		2d. HOUR <i>A M</i>		
7a. BIRTHPLACE (State or foreign country) <i>Balt. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co</i>				
10. CITY OR TOWN OF DEATH <i>A.A. Co.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Annapolis Gen'l Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-0-</i>				
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Franklin & Gibson Rd.</i>	
14. FATHER'S NAME First <i>Eugene</i> Middle <i>Mitchell</i> Last <i>Mitchell</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>E.</i> Last <i>Wallace</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>0-</i>		17. INFORMANT <i>Mr. Eugene Mitchell</i>		17. ADDRESS <i>SAME</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute upper Respiratory Infection</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>E. Howard St.</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>1.22.69</i>				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county) <i>AMCO.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/27/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat'l Cem.</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) _____ (State) <i>Md</i>		
24. FUNERAL DIRECTOR <i>Morton & Dyck F.H.</i>			ADDRESS <i>1701 Laurens St.</i>			25a. REC'D BY REGISTRAR <i>JAN 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00203

00202

1. DECEASED-NAME (Type or print) EDWARD FRANCIS Monaghan			2a. DATE OF DEATH January Month 29 Day 1969 Year		2b. HOUR 7:35 P.M.
3. SEX MALE	4. RACE CAU	5. DATE OF BIRTH June 7, 1911		6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penn'a	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Co Md.		
10. CITY OR TOWN OF DEATH Arnold	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT 2 Box 358	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auditor	12b. KIND OF BUSINESS OR INDUSTRY State of Md		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT 2 PO Box 358	
14. FATHER'S NAME First Middle Last Thomps Joseph Monaghan	15. MOTHER'S MAIDEN NAME First Middle Last MARY Veronica Scully				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes give war or dates of service) YES ARMY AIR Force	16b. SOCIAL SECURITY NO. 179-183189	17. INFORMANT FRANCIS MONAGHAN Address RT 2 Box 358 Arnold Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCITES + EDEMA 5710 DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLISM					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks one year years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 18, 1969 , to Jan 12, 1969 , that (I) (we) last saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death.					
22b. SIGNATURE T.C. Cullis MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 29-January 1969	
22d. PHYSICIAN'S NAME (Type) T. C. Cullis MD		22e. ADDRESS Hahn Professional Building Severna Park			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/3/69	23c. NAME OF CEMETERY OR CREMATORY East National	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Robert S. Benenmed		ADDRESS Severna Park, Md	25a. REC'D BY REGISTRAR FEB 3 1969	25b. REGISTRAR'S SIGNATURE William A. Under	

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RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last ETHEL MAE MOORE						2a. DATE OF DEATH Jan Month 10 Day 1969 Year			2b. HOUR 7:30 P.M.		
3. SEX FEMALE		4. RACE COLORED		5. DATE OF BIRTH FEB 15-1927		6. AGE (In years last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) WELINGTON SL		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N.H. GEN HOP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN FREETOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt 1-301K			
14. FATHER'S NAME First Middle Last NATHANIEL COTTON				15. MOTHER'S MAIDEN NAME First Middle Last MARY ELIA KING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 4109		17. INFORMANT Address DAVID MOORE Rt 1-301K GLEN BURNIE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 4109										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1968 , to Jan 10, 1969 , that (I) (we) lost saw the deceased alive on Jan 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R.M. McLaughlin, M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/14/69			
22d. PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D.						22e. ADDRESS Paradise, Md. 21122					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/15/69		23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City or Town) (County) (State) HAVERVILLE S.C.					
24. FUNERAL DIRECTOR Marshall P. Hays ADDRESS 638 N. Gilmer St						25a. REC'D BY REGISTRAR JAN 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P		
Charles			G. Morningstar, Sr.			1 19 69		7:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		7-19-06		62 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel			retired (Fireman)				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Anne Ar.		Glen Burnie		NO		7976 Cross Creek Dr.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Charles P. Morningstar			Rosenia Bishop							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No				Mas. Agnes Morningstar		7976 Cross Creek Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 1969</u> , to <u>1-19-69</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>Harry T. O'Herlihy</u>								<u>1-19-69</u>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
<u>Harry T. O'Herlihy</u>		<u>325 Hospital Drive</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>1/22/69</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, "Annapolis"</u>				
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>John A. Moran, Inc.</u>		<u>3000 E. Baltimore St.</u>				<u>JAN 22 1969</u>		<u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00206

CERTIFICATE OF DEATH

00205

1. DECEASED-NAME (Type or print) Baby Girl			First Middle Lost			2a. DATE OF DEATH Month 1 Day 4 Year 69			2b. HOUR 1:10 AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Jan. 3, 1969			6. AGE (In years lost birthday) YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N. Arundel Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY ///		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 112 Olan Dr. (Ferndale)			14. FATHER'S NAME First Howard Middle Herold Lost Naumann			15. MOTHER'S MAIDEN NAME First Marjorie Middle J. Lost Naumann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. none			17. INFORMANT Mr. John Naumann (grandfather)			Address Same As #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 777X <i>Immaturity</i> Birth wt 11 lb 11 oz DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. prematurity (b) 6 months pregnancy DUE TO, OR AS A CONSEQUENCE OF (c) 6 months pregnancy										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/3/69 , 19 69 , to 1/4/69 , 19 69 , that (I) (we) last saw the deceased alive on 1/3/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Allan Y. Wolins M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/4/69		
22d. PHYSICIAN'S NAME (Type) ALLAN Y. WOLINS, M.D.						22e. ADDRESS 325 HOSPITAL DR. GLEN BURNIE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Jan. 6/69			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland		
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.						25a. REC'D BY REGISTRAR JAN 8 1969			25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>		

VP 115 (4)
MAY 22 1968

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CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR				
Blanche							Neibert		Month 1 Day 5 Year 48		P M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
F		W		April 11, 1902		66 YRS.		MONTHS DAYS		HOURS MIN.		Month 1 Day 5 Year 1969			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			2d. HOUR			
Lithuania			U.S.						Anne Arundel			P M			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
glen Burnie				SEA-NORTH ARUNDL				Seamstress				Wohlmut Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				A. A.				Biviera Beach				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8564 Main Ave.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
-----				Kabis				unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO				217-26-6339				Harry Neibert				(same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Cardiac disease</u>															
4299 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. 19 P.M.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				M.D.				1-5-69							
George J. /Gonce				E. Linhardt				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)				Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				1-8-1969				Parkwood Cemetery				Baltimore, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George J. /Gonce				4001 Ritchie Hgwy., Baltimore				JAN 10 1969				[Signature]			

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UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00208		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00207	
1. DECEASED-NAME (Type or print) Bernard Charles O'Brien		First Middle Last		2a. DATE OF DEATH January 5 1969		2b. HOUR 3:00 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 3, 1911		6. AGE (In years last birthday) 57 100 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Bernard (N) O'Brien		15. MOTHER'S MAIDEN NAME Elizabeth (N) Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-03-5904	
17. INFORMANT Philip O'Brien		Address Severna Park		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 471X PNEUMONIA IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF INFLUENZA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. Arteriosclerotic heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) 5 YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 14 DAYS 5 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (A) (this hospital) attended the deceased from Dec 14, 1968 , to Jan 5, 1969 , that (B) (we) last saw the deceased alive on January 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J.C. Cullis MD		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED January 5, 1969	
22d. PHYSICIAN'S NAME (Type) J. C. Cullis MD		22e. ADDRESS Hahn Professional Building Severna Park					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/8/69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. #21212		25a. REC'D BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Lawrence J. O'Connor, Jr.						1 Month 29 Day 69 Year		8:24 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male		White		November 4, 1913		55 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Linthicum		North Arundel		Banker		Bank			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Anne Arundel		Linthicum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		112 Sycamore Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
Lawrence J. O'Connor, Sr.						Mary			-----
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
Yes			W.W.11			Laura O'Connor, 112 Sycamore Rd., Linthicum			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>									9 months
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
9/3/68		good			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year							
(If either, notify medical examiner)		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/>									
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Jan. 29, 19 69 to Jan. 29, 19 69, that (I) (we) last saw the deceased alive on Jan. 29, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Paul J. Chang MD									1/29/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Paul J. Chang MD					801 Crim Hwy SE Glen Burnie				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-3-1969		Baltimore National Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
George J. Gonce, 4001 Ritchie Hwy., Baltimore							FEB 5 1969		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00209

1. DECEASED-NAME (Type or print) First Middle Last <i>James Edward O'Neill</i>			2a. DATE OF DEATH Month Day Year <i>January 5 69</i>		2b. HOUR <i>11A M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>MAY 20, 1893</i>		6. AGE (in years last birthday) YRS. <i>75</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Lothian, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>A A Co</i> Md.		
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A A Gen. Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>FARMER</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>A.A Co.</i>	13c. CITY OR TOWN <i>HARWOOD</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>HUGH O'NEILL</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>FLORENCE DRURY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>212-36-6382</i>	17. INFORMANT Address <i>DAISY O'Neill HARWOOD, Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>4122</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>62</i> , to <i>Jan 5</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 4</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Willard F. Smith</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/5/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Willard F. Smith</i>		22e. ADDRESS <i>Shady Side, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>Jan 8, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion</i>		23d. LOCATION (City or Town) (County) (State) <i>Lothian A A Md</i>	
24. FUNERAL DIRECTOR <i>Hardisty Funeral Home, Annapolis, Md</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JAN 7 1969</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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OFFICE OF THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

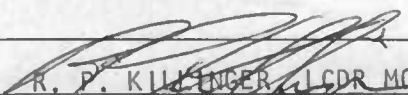
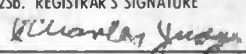
1

00211

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00210

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) BABY			First BABY	Middle BOY	Lost PAJE	2a. DATE OF DEATH January ^{Month} 21 ^{Dpy} 69 ^{Year}			2b. HOUR 2045 M		
3. SEX Male		4. RACE Malayan		5. DATE OF BIRTH January 21, 1969		6. AGE (In years lost birthday) — YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? Philippines		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N.A.			12b. KIND OF BUSINESS OR INDUSTRY N.A.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 Maryland Avenue			
14. FATHER'S NAME Patrocinio			First M.	Middle Paje	15. MOTHER'S MAIDEN NAME Rizalina			First S.	Middle Sicon	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Patrocinio Paje Address 2 Maryland Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 50 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE  R. P. KULLINGER, LCDR MC USN						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED January 21, 1969			
22d. PHYSICIAN'S NAME (Type) R. P. KULLINGER						22e. ADDRESS 45th AOSPT. Annapolis MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-23-69		23c. NAME OF CEMETERY OR CREMATORY U.S.N. Academy				23d. LOCATION (City or Town) (County) (State) Annapolis A.D. - MD			
24. FUNERAL DIRECTOR John M. F. Farhas						ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE 	

2019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) AGATHA First Middle Last PALMISANO						2a. DATE OF DEATH Month JANUARY Day 31 Year 1969			2b. HOUR 740 P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-03-92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? ITALY		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL			Md.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDEL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --					
13a. USUAL RESIDENCE (Where decedent lived, if institution: Residence before admission) XXXX RD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1207 RAMBLEWOOD ROAD			
14. FATHER'S NAME First Angelo Middle Ragonese Last Ragonese				15. MOTHER'S MAIDEN NAME First Antoinette Middle ? Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-28-1720D		17. INFORMANT ANTHONY PALMISANO				Address 58 BELMORE RD. LUTHERVILLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Orlando C. Ramos MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1-31-69					
22d. PHYSICIAN'S NAME (Type) Orlando C. Ramos MD						22e. ADDRESS 1549 Woodbourne Ave Balto 21212					
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE 2/4/1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Eugenia K. Seitz ADDRESS Seitz Funeral Home Balto. Md. 21212						25a. REC'D BY REGISTRAR DATE FEB 7 1969		25b. REGISTRAR'S SIGNATURE Orlando C. Ramos			

(11-11)

11-11-11

1-1-11

(Ladies' room)
Ventilation
refrigerated information

1-1-11

Colonoscopy
Colonoscopy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00213 CERTIFICATE OF DEATH 00212									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILLIAM EDWARD PARDOE, Sr.						Month Day Year January 14, 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		May 29, 1913		55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Maryland		U. S.				Anne Arundel Co.,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		N. Arundel General Hosp.		Well Driller		Well Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		A. A.		Clearwater Beach				801 Waterview Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last William C. Pardoe			First Middle Last Elsie E. Bowen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			213-03-6871		Mrs. Alma Pardoe (same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Blood, Trachea ruptured</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pest - irradiation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca. of Lung & Lower Trachea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
Frank A. Faraino, M.D.		1-15-1969			Frank A. Faraino, M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 17, 1969		Glen Haven Memorial Pk.		Ritchie Hwy., A.A. Co., Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George J. Gonce, 4001 Ritchie H gwy., Baltimore		JAN 21 1969		Charles Judge					

8100

CERTIFICATE OF DEATH

0031



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
45M - 69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) James Washington Parker					2a. DATE OF DEATH Month January Day 19 Year 1969			2b. HOUR 6: A M		
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH January 10, 1896			6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Co. Md.				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Contractor			12b. KIND OF BUSINESS OR INDUSTRY *****	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY A.A. Co.		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First George Middle NMN Last Parker					15. MOTHER'S MAIDEN NAME First Issabelle Middle NMN Last Addison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 218-14-2190A		17. INFORMANT Address 304 Bestgate Rd MA Margaret J. Peters					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Cardiovascular thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 4339 clusterly.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from July , 19 68 , to Jan , 19 69 , that (1) (we) last saw the deceased alive on Jan 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Hedeman MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/21/69			
22d. PHYSICIAN'S NAME (Type) John Hedeman					22e. ADDRESS 1407 Forest Drive, Annapolis, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-23-69		23c. NAME OF CEMETERY OR CREMATORY Fowlers		23d. LOCATION (City or Town) (County) (State) A.A. Co Md				
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md					25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A 5
45M 1/1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George			NMN			PHELPS, Sr.			January 23 1969 7:05 P.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		Feb. 22, 1899		69 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hospital			Cook			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		110 South St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Charles NMN Phelps			Anna NMN Booze						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			WWI		214-14-6617 Louise H. Phelps 110 South St. Anne, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral cerebral failure every heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Yes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1967, to 1/23, 1969, that (I) (we) lost the deceased on 1/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gordon Church					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/24/69		
22d. PHYSICIAN'S NAME (Type) Gordon Church					22e. ADDRESS 121 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-27-69		Pine Lawn		Annapolis A.A. Md			
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md					25a. RECEIVED BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE Judge		

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
JENNIE					POSSON	Month	Day	Year	259 P M		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F	W		7-16-73			9.5 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
ny		USA				A.A. B					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
millederville			KROGWOOD MANOR N.H.			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
md			AA		SEVERNA PARK	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13 EARLEIGH Hgb Rd			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George					Wainer	Elin					Zimmerman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mr Richard Posson			Above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hemorrhage from gastrointestinal tract											
DUE TO, OR AS A CONSEQUENCE OF (b) Thrombocytopenia										1 day	
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Leukemia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1969, to Jan 30, 1969, that (I) (we) last saw the deceased alive on Jan 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
R M Smith M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			Jan 30, 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
R.M. SMITH, M.D.						SEVERNA PARK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/3/69		Park View An			Schenectady N.Y.			
24. FUNERAL DIRECTOR						25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert S. Samanco, Severna Park, Md.						DATE FEB 3 1969			[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) <i>EARL R. Pumphrey Jr</i>			2a. DATE KNOWN OF DEATH Month <i>1</i> Day <i>24</i> Year <i>1969</i>			2b. HOUR <i>7</i> M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>June 23 1901</i>	6. AGE (In years last birthday) <i>67</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>24</i> Year <i>1969</i>			2d. HOUR <i>7</i> M
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A. Co</i>			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Dor- March Amundel</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Crane Operator (ret.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8th Avenue N.W.</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Pumphrey</i> Last <i>Pumphrey</i>			15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Neident</i> Last <i>Neident</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-16-1292</i>		17. INFORMANT <i>Mrs. Ethel E. Pumphrey (wife)</i>		ADDRESS <i>Same As #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun Shot Wound Fore & Skull</i> <i>955 X</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M. 1-24 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Self inflicted gunshot wound</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>SPCO. MD</i>		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhart</i>		EXAMINER'S NAME (Type) <i>E. Linhart</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>1-24-69</i>	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>A.A. Co.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 28, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. PK</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie, Md.</i>			
24. FUNERAL DIRECTOR <i>R. Singleton</i>		ADDRESS <i>Singleton Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Glen Burnie, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>JAN 30 1969</i>	

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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PLANT
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 14-1
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Glenn Irving PUTNAM						January 21 1969			4:15 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		Dec. 18, 1921		47 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Florida		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Annapolis			Anne Arundel Gen. Hospital			Contractor			BUILDING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Mayo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Mayo Post Office
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
GLENN I PUTNAM SR.			MARY LORISSIA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES			WW 2		HELEN M. PUTNAM # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									48 hours
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Overload of the liver with portal hypertension, Massive obesity</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20, 1969</u> , to <u>1/21, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/21/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22e. ADDRESS <u>16 Murray Ave., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>1/24/1969</u>		<u>FORT LINCOLN CEM</u>		<u>PRINCE GEO. Co MD.</u>			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>JOHN M. TAYLOR SONS ANNAPOLIS MD.</u>				<u>JAN 22 1969</u>		<u>Charles Judge</u>			

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• **RESEARCH** •

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
RICHARD OSCAR QUILL						1 4 19			M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Aug 3 1915	55 YRS.					1 Day 4 Year 19	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Mo.
North Dakota		USA				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		AA General Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Md			AACo		Round Bay			116 Severn River Rd.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Last
Theodore I. Quill						Emma			Rossing
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS
yes			1945-1945 577 14 7202		Doris Quill Round Bay, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4299 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED 1/4/69							
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <u>[Signature]</u>							
EXAMINER'S NAME (Type) <u>E. Linhardt</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/5/69		Woodfield		Galesville, Md AACo			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Hardesty Funeral Home				Annapolis, Md		JAN 7 1969		<u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00220

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00219

1. DECEASED-NAME (Type or print)		First JAMES	Middle EDWARD	Last RANKIN	2a. DATE OF DEATH JAN Month 13 Day 1969 Year		2b. HOUR 1:45 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan 13, 1969		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Ft Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #1, Box 200			
14. FATHER'S NAME First David		Middle Rankin		15. MOTHER'S MAIDEN NAME First Barbara		Middle Faulkner		Last Faulkner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give year or dates of service) N/A		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address David Rankin, Route #1, Box 200, Laurel, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DEPRESSION 776.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hrs 8 Min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that 3 (this hospital) attended the deceased from 13 Jan , 19 69 , to 13 Jan , 19 69 , that 4 (we) lost saw the deceased alive on 13 Jan , 19 69 ; and that in my (our) opinion death occurred on the date and hour and from the causes stated above, 1 (we) (did) not view the body after death.											
22b. SIGNATURE William J. Weston MD					DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 13 Jan 1969		
22d. PHYSICIAN'S NAME (Type) WILLIAM L. WESTON, CPT, MC,					22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 16, 1969		23c. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEM.			23d. LOCATION (City or Town) LOWELL		(County) N.C.		(State)
24. FUNERAL DIRECTOR ADWARD COUNTY F.H. ELLICOTT CITY					ADDRESS MD		25a. REC'D BY REGISTRAR DATE JAN 18 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

UNITED STATES DEPARTMENT OF AGRICULTURE

103-55-2 AND 3 AND 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P.		
William Joseph REID						Jan. 6, 1969		5:18 M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Jan. 31, 1999		69 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			AA General			Postal Clerk		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md			AACo		Mayo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1603 Cliff Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas Reid			Sarah Tacey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			1918-19		216 44 7675 Wm. R. Reid Mayo, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery insufficiency + sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Syn-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>chestnut</u> <u>5 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>Jan.</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John L. Hedeman</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/9/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>John L. Hedeman, M.D.</u>		22e. ADDRESS <u>1407 Forest Dr., Annapolis, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 10, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash, DC</u>				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Hardesty Funeral Home		Annapolis, Md.		JAN 13 1969		<u>John L. Hedeman</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00222 CERTIFICATE OF DEATH 00221									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Thelma					Reimsnyder	Month	Day	Year	6:30aM
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Female			White		5/1/98	70 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
unknown Md.			USA				Anne Arundel Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Crownsville			Crownsville State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Hanover			Hanover Road Box 1-B	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
unknown			Grimm			unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No unknown			unknown		Hospital Records, Crownsville State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Pneumonitis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic cardio vascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Hyperthyroidism</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19/68</u> , 19 <u>68</u> , to <u>1/6/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/6/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles R. Venter, M.D.</u>						22c. DATE SIGNED <u>1/7/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Charles R. Venter, M.D.</u>						22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			1-17-1969		Zion Cemetery		Baltimore Howard Md.		
24. FUNERAL DIRECTOR ADDRESS <u>21229</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard 4107 Wilkens Ave. Baltimore						JAN 21 1969		<u>Charles Judge</u>	

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
00223															
00222															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First JOHN		Middle ERNEST		Last REINBURG Jr.		20. DATE OF DEATH Month Day Year January 16 1969		2b. HOUR 7:45A ^M				
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 30 August 1893			6. AGE (In years lost birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL			Md.			
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NAVY - Capt. Ret.			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 207 NORWOOD ROAD			
14. FATHER'S NAME First Middle Last JOHN ERNEST REINBURG			15. MOTHER'S MAIDEN NAME First Middle Last LOUMINOR NEBANE												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO. 1916-1955			17. INFORMANT MRS. FRANCES REINBURG			Address 207 NORWOOD ROAD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 340X IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Michael F. Fornes MD			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) M.F. FORNES, LCDR MC USN			22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD. 21402												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-17-69			23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.			23d. LOCATION (City or Town) (County) (State) Arlington, Va.						
24. FUNERAL DIRECTOR John M. Taylor & Son Annapolis, Md.			25a. MARKED BY JAN 20 1969			25b. REGISTRAR'S SIGNATURE									

88860

88860

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, including dates and references]

RE: [Illegible]

CIVIL RIGHTS DIVISION

[Large circular stamp, likely a filing or processing mark]

APPROVED: [Illegible Signature]
SPECIAL AGENT IN CHARGE
[Illegible text at bottom]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00224		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00223					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Carrie		Middle L.		Last Richardson		2a. DATE OF DEATH 1 Month 22 Day 69 Year		2b. HOUR 11:50 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-8-82		6. AGE (In years lost birth date) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co. Md.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 413 3rd. Ave. S.W.			
14. FATHER'S NAME First Ludwig		Middle T.		Last Pyeritz		15. MOTHER'S MAIDEN NAME First Sophia		Middle Hammerstrom		Last Elvaton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 213-05-8313-0		17. INFORMANT Address Mrs. Norman Richardson (grandson) Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD - DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia, CHF, Fracture hip.											
19a. DATE OF OPERATION 12/24/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 12 22 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Fell at home							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home		21f. LOCATION Street or R.F.D. No. 413-3rd Ave SW		City or Town Glen Burnie		County AA		State Md	
22a. I certify that (I) (this hospital) attended the deceased from 12/23/68, 19__, to 1/22/69, 19__, that (I) (we) last saw the deceased alive on 1/22/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jorge B. Ramirez M.D.		22c. DATE SIGNED 1/23/69		22d. PHYSICIAN'S NAME (Type) Jorge B. Ramirez M.D.		22e. ADDRESS 325 Hospital Dr or Glen Burnie 21061 3927 Annapolis Rd Balto 21 md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/25/69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR E.B. Flanagan		25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
00225		00224									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
KENNETH		BIERD		ROYLANCE		JAN		19 Day 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MAY 11, 1893		73 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
SPRINGVILLE UTAH		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS		ANNAP. CONVAL. HOME		MUSIC INSTRUCTOR		PUBLIC SCHOOLS					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MD.		A.A.C.		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1035 NORMAN DR.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
AARON		W.		ROYLANCE		CHARLOTTE		E.		BERRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						MRS. UNA MARIE ROYLANCE #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinson's disease, Fracture @ Glenoid Scapula											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/16, 1969, to 1/19, 1969, that (I) (we) lost saw the deceased alive on 1/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. DATE SIGNED					
R. BIERN		4/19/69				4/19/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				22f. ADDRESS					
R. BIERN		121 CATHEDRAL ST ANNAPOLIS MD				121 CATHEDRAL ST ANNAPOLIS MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		1/21/1969		HILLCREST Cem.		ANNAPOLIS AACG MD.					
24. FUNERAL DIRECTOR		ADDRESS				25. REC'D BY REGISTRAR		25f. REGISTRAR'S SIGNATURE			
John M. Taylor Sons		Annapolis, Md.				JAN 22 1969					

25800

OFFICE OF THE

25800

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

[Illegible text block containing the main body of the memorandum, including details of the investigation and administrative notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 415 (4)
304A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
00226 CERTIFICATE OF DEATH 00225													
1. DECEASED-NAME (Type or print)			First	Middle	last	2a. DATE OF DEATH			2b. HOUR				
William			H		Ryan	Month 1 Day 25 Year 69			3:00 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN					
m		White		Jan. 15, 1885		89 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.				A.A. CO.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS			ANNAPOLIS NURSING HOME			MACHINIST		U.S. N. YARD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
MD			A.A. CO.		Shoemaker Beach EGGSWATER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1427 YANKEE DR.				
14. FATHER'S NAME			First	Middle	last	15. MOTHER'S MAIDEN NAME			First	Middle	last		
FRED CASPER					RYAN	Mary					Dooley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
						CLARA M. RYAN			# 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia Immediate cause													
1991 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Circulatory failure, within approx one hour													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Squamous Cell Carcinoma, origin unknown. One year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE												22c. DATE SIGNED	
William H. Choate, MD DEGREE												25 Jan 1969	
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			1/28/1969		HILLCREST CEM			ANNAPOLIS MD					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John M. Layton & Sons Annapolis, Md.						DATE JAN 28 1969		Charles Judge					

00225

00225

YAWA 88

Handwritten notes and stamps, including "YAWA 88" and "JAN 22 1968".

Handwritten notes and stamps at the bottom of the page.

00227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
August Gaspero Scardina						ESTIMATED <input type="checkbox"/> 1-1					1969	A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
M	W	Apr. 1, 1896		72 YRS.		MONTHS DAYS		HOURS MIN.		Month 1 Day 1 Year 1969		A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Sicily		U.S.A.				Anne Arundel Co. Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie			Dea North Brunel			Ret. Tavern Operator						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md			A.A.Co.			Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 2 Box 180	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Cologero					Scardina	Josephine					Serio	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes			WW II			Mr. George Scardina			Route 2 Box 180 G.B.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>arteriosclerotic C.V.D.</u>												<u>1 hour</u>
4124 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>E. Linhardt</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						1-1-69
EXAMINER'S NAME (Type) <u>E. Linhardt</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						A.A.Co.
						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			1/4/69		Glen Haven			Glen Burnie, Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
McCully F.R. 237 Patapsco Ave						DATE JAN 6 1969			J. Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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00228

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00227

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Karl C. Schoene						Month Day Year			3:05 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	white	March 17, 1954	14 YRS	MONTHS	DAYS	HOURS	MIN.	January 17, 1969			3:05 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Maryland		U. S.		WIDOWED		DIVORCED		Anne Arundel Baltimore County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Brooklyn Park			128 9 Ballman Ct.,			Schoolboy					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Anne Arundel Co.			Brooklyn Pk.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Karl O. Schoene			Alice V. Shewbridge			No			p-----		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mr. Karl O. Schoene			- same			PART 1. DEATH WAS CAUSED BY:					
						IMMEDIATE CAUSE (a) shotgun wound of neck					
						DUE TO, OR AS A CONSEQUENCE OF					
						(b)					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				3:05 P.M. 1, 17 1969				gun discharged in contact with neck			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
				building				9 Ballman Ct. Baltimore Co., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER							
Werner U. Spitz, M.D.				DEPUTY MEDICAL EXAMINER							
				ADDRESS (Street, city, town, or county)							
								Jan 18, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1-21-1969			Baltimore National Cem.			Baltimore, Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George J. Gonce, 4001 Ritchie Hwy., Baltimore						JAN 23 1969			Charles Judge		

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U.S. DEPARTMENT OF THE ARMY
MEDICAL DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00222		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00228	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Catherine</i>		First Middle Last <i>Sedlak</i>		2a. DATE OF DEATH Month <i>1</i> Day <i>30</i> Year <i>69</i>		2b. HOUR <i>6:20</i> M	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>10/28/1928</i>		6. AGE (In years last birthday) <i>70</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.	
10. CITY OR TOWN OF DEATH <i>Ben Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel Convalescent Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>49 St. Andrews Rd.</i>		14. FATHER'S NAME First Middle Last <i>William ---- Zayo</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Theresa ---- Buddie</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>198-20-4238</i>		17. INFORMANT Address <i>Mrs. Catherine Gullifer, 49 St. Andrews Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>2509</i> (b) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>20 yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John I. Stern</i>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>John I. Stern</i>				22e. ADDRESS <i>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-3-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Ritchie Hgwy., A.A.Co., Md.</i>	
24. FUNERAL DIRECTOR <i>George J. Gonce, 4001 Ritchie Hgwy., Baltimore</i>				25a. REC'D BY REGISTRAR <i>FEB 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W. Chalmers Young</i>	

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Item 1 Film 409 2/5/69 kk

CERTIFICATE OF DEATH

00229

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn, Baltimore, Md. 21225	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4209 3rd Street				d. STREET ADDRESS 4209 3rd Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Florence Last Sieg				4. DATE OF DEATH Month January Day 29 Year 1969			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1913		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months 1 Days 19 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George C. Ernest				14. MOTHER'S MAIDEN NAME Olia Linton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address 21225 Mrs. Audrey E. Schilpp 601 Hopkins St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 398X IMMEDIATE CAUSE (a) Rheumatic heart disease and carcinoma of lung with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above							
22a. SIGNATURE <i>Edward F. Wilson</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward F. Wilson, M.D.				22d. ADDRESS 700 Fleet St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR McCully F. H. 237 Patapsco Ave. 21225				25a. REC'D BY REGISTRAR DATE JAN 31 1969		25b. REGISTRAR'S SIGNATURE <i>Richard A. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First		Middle		Last		Month		Day		Year	
EFFIE		NORWOOD		SMITH		January		23		1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		9 March 1897		71 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Solomon Island, Md.		U.S.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Naval Hospital			Housewife			NONE		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel			Annapolis				134 Market Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Gus			Evans			Molley ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			220-16-9014			HOWARD S. SMITH			# 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC PULMONARY EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M.F. Fornes</u>						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-23-69	
22d. PHYSICIAN'S NAME (Type) M.F. FORNES, LCDR MC USN						22e. ADDRESS U.S.O.A. Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial			1-28-69		Huntington Nat'l		Annapolis		Anne Arundel		MD.
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John M. Gaybe Sr. Annapolis, Md.								JAN 27 1969			

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RECEIVED
BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

1954

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

[Large block of illegible text, likely a memorandum or report body]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) EVELYN M. SMITH						2a. DATE OF DEATH Month 1 Day 12 Year 69		2b. HOUR 11:50 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-11-07		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS 6 DAYS 1		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Co.				
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDEL Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) photographer		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN SEVERNA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 613 Cypress LAINE	
14. FATHER'S NAME First JAMES H Middle NORTON Last DAISY M. HEATH			15. MOTHER'S MAIDEN NAME First DAISY M. Middle HEATH Last SMITH			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or as unknown (If yes give war or dates of service) No				
16b. SOCIAL SECURITY NO. 3950			17. INFORMANT BURTON L. SMITH - ABOVE			17. ADDRESS Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation (pulmonary edema) 3950 DUE TO, OR AS A CONSEQUENCE OF (b) Aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic fever, probable Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days Many years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastases to lungs and liver from carcinoma of colon.										
19a. DATE OF OPERATION Dec. 23, '65		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of sigmoid colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 12 Day 23 Year 1965 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 3 , 19 65 , to Dec. 4 , 19 68 , that (I) (we) last saw the deceased alive on Dec. 4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Tilden Howard, M.D.		22c. DATE SIGNED Jan. 15 '69		22d. PHYSICIAN'S NAME (Type) John Tilden Howard, M. D.		22e. ADDRESS 12 E. Eager St., Baltimore, Maryland		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-16-69		23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE CEM		23d. LOCATION (City or Town) (County) (State) DORSEY Hov. Md		23e. REC'D BY REGISTRAR Charles Judge		
24. FUNERAL DIRECTOR Paul S. Berraneco, Severna Ph. Inc.		24b. ADDRESS Severna Ph. Inc.		24c. DATE JAN 17 1969		24d. REGISTRAR'S SIGNATURE Charles Judge		24e. ADDRESS		

1968

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UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY OF DEFENSE

1. NAME (Last, First, Middle Initial)	
2. ADDRESS (Street, City, State, Zip)	
3. PHONE NUMBER (Area Code, Number)	
4. OCCUPATION	
5. EDUCATION	
6. MARITAL STATUS	
7. NUMBER OF CHILDREN	
8. DATE OF BIRTH	
9. SOCIAL SECURITY NUMBER	
10. GRADE	
11. SERVICE NUMBER	
12. BRANCH	
13. GRADE	
14. SERVICE NUMBER	
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97. GRADE	
98. SERVICE NUMBER	
99. BRANCH	
100. GRADE	

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301
1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00233										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00232																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
John Smith										Jan. 8 Day 69 Year										10:24 p.m.																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH 10-3-97										6. AGE (In years last birthday) 71 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Penna.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.																													
10. CITY OR TOWN OF DEATH Glen Burnie										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) truck driver-retired										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Howard										13c. CITY OR TOWN Dorsey										13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER Box 409 Rt. 4																			
14. FATHER'S NAME First Middle Last Ralph Smith										15. MOTHER'S MAIDEN NAME First Middle Last Ida Ness																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give year or dates of service) NO										16b. SOCIAL SECURITY NO. 215.14.5338										17. INFORMANT Lydia Smith Address Same as # 13																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Left ventricular failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis Approximate interval between onset and death: Hours 1 Month 1 Year										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1/8 1969, to 1/8 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Max C Frank										22c. DATE SIGNED 1/9/69																																							
22d. PHYSICIAN'S NAME (Type) MAX C FRANK										22e. ADDRESS 425 SE Ritchie Hwy Glen Burnie																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 13, 1969										23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery										23d. LOCATION (City or Town) (County) (State) Dorsey Maryland																													
24. FUNERAL DIRECTOR J.T. Stansbury										ADDRESS 6411 Windsor Mill Road										25a. REC'D BY REGISTRAR JAN 13 1969										25b. REGISTRAR'S SIGNATURE																													

\$25.00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00234										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00233																													
1. DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR M																			
William R. Smuck																				Jan. 21, 1969																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH July 14, 1946										6. AGE (In years at birthday) 22 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel, Md.																			
10. CITY OR TOWN OF DEATH Balto. Suburban										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8050 Ritchie Hwy.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Contractor										12b. KIND OF BUSINESS OR INDUSTRY self-employed																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Anne Arundel										13c. CITY OR TOWN Balto. Sub.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 6050 Ritchie Hwy.									
14. FATHER'S NAME Harry A. Smuck										15. MOTHER'S MAIDEN NAME Thelma Prodoehl																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 214-46-2368										17. INFORMANT Mrs. Anita Marocco										Address Same									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute leukemia, myeloblastic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 32 mos.																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION 0										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from May 1966, to Jan. 21, 1969, that (I) (we) lost saw the deceased alive on Jan 20, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Wm Carl Ebeling										22c. DATE SIGNED 1-21-1969																																							
22d. PHYSICIAN'S NAME (Type) William Carl Ebeling, M.D.										22e. ADDRESS 701 St. Paul St., Baltimore, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 24, 1969										23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery										23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A.Co., Md.																			
24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie H gwy., Baltimore										25a. REC'D BY REGISTRAR JAN 29 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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STATEMENT OF WORK

STATEMENT OF WORK FOR THE DEVELOPMENT OF A NEW PRODUCT

1. PROJECT NAME

2. PROJECT NUMBER

3. PROJECT START DATE

4. PROJECT END DATE

5. PROJECT MANAGER

6. PROJECT STATUS

7. PROJECT DESCRIPTION

8. PROJECT OBJECTIVES

9. PROJECT SCOPE

10. PROJECT BUDGET	11. PROJECT RISK
12. PROJECT BENEFITS	13. PROJECT CHALLENGES
14. PROJECT DELIVERABLES	15. PROJECT MILESTONES
16. PROJECT RESOURCES	17. PROJECT STAKEHOLDERS
18. PROJECT COMMUNICATIONS	19. PROJECT MONITORING
20. PROJECT EVALUATION	21. PROJECT CLOSURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/78

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00235 CERTIFICATE OF DEATH 00234									
1. DECEASED-NAME (Type or print) JENNIFER			First Middle Last			2a. DATE OF DEATH JAN Month 14 Day 1969 Year		2b. HOUR 9:23 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan 13, 1969		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 13 22	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Ft Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 20 Cort Pleasant, Apt C-4	
14. FATHER'S NAME First Middle Last David Livingston Spangler				15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Jean Gelbutts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Address David L. Spangler, 20 Court Pleasant, Apt C-4					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY & CARDIAC FAILURE 7762 DUE TO, OR AS A CONSEQUENCE OF PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 13 Jan , 19 69 , to 14 Jan , 19 69 , that (I) (we) last saw the deceased alive on 14 Jan , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael A. Lee M.D.				22c. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT. MEADE, MD		22d. DATE SIGNED 14 January 69			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 16 69		23c. NAME OF CEMETERY OR CREMATORY ST. CASHIERS		23d. LOCATION (City or Town) (County) (State) POTTSVILLE, PENNA			
24. FUNERAL DIRECTOR HOPE WITTE				ADDRESS 21043 ELMONT CITY, MD.		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|-------------------|--|--|--|--|---|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 00236 | | | | | | | | | | |
| 00235 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Ruth Frances SPRIGGS | | | | | | January 19 1969 | | 3:10 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| Female | | White | | April 4, 1906 | | 62 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Maryland | | U.S. | | | | Anne Arundel | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Annapolis | | Anne Arundel Gen. Hospital | | hairdresser | | own business | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Anne Arundel | | Weems Creek | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | -- | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| Harry Spriggs | | | | | | Ammanda Louie Woodon | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| no | | 214-05-1431 | | John W. Smith - 614 Ridgley Ave. Weems Creek | | Annapolis, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Vascular Accident (1950) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19, 1963 to July 19, 1969, that (I) (we) last saw the deceased alive on July 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | |
| Edward S. Beck | | 4/29/69 | | Edward S. Beck, M.D. | | 73 Franklin St., Annapolis, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1/21/69 | | Cedar Bluff Cemetery | | Annapolis A. A. Md. | | | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. REG. REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Beverly E. Hopping | | Beverly E. Hopping | | JAN 23 1969 | | James Judge | | | | |
| HOPPING FUNERAL HOME - Annapolis, Md. | | | | | | | | | | |

RESOL

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APPROX. 11.49. 11.50. 11.51. 11.52. 11.53. 11.54. 11.55. 11.56. 11.57. 11.58. 11.59. 12.00.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Mazie | | | | | | | | | |
|--|--|--|--|--------|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| Mazie | | | A | | Staylor | Month | Day | Year | M |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR |
| F | | | Caucasian | | XXXX 9/15/83 | | 85 YRS. | | MONTHS |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | | USA | | | | A. A. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Pasadena | | | 4104 Arundel Ct | | | Seamstress | | | Retired |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Md | | | A. A. | | Pasadena | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4104 Arundel Ct |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | |
| Moses O. Atkinson | | | | | | Henrietta Mund | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 213-01-0931 | | Mrs Mazie Precht Same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Lobar Pneumonia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Congestive Heart Failure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/17/64, 19__, to 8/20/68, 19__, that (I) (we) last saw the deceased alive on 8/20/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| C. Earl Hill | | | | | | | | 1/27/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| C. Earl Hill, M. D. | | | | | | 395 Ft. Smallwood Rd., Pasadena, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 1/30/69 | | Loudon Park | | Catonsville, Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 6212 Balt. Nat. Pike West Inc | | | | | | JAN 31 1969 | | Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Wayne B. Steinman | | | | | | 2a. DATE OF DEATH Month Day Year
1 28 69 | | | 2b. HOUR
8:20 P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
September 7, 1925 | | | 6. AGE (In years last birthday)
43 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Anne Arundel Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie, Maryland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
North Arundel | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | | 12b. KIND OF BUSINESS OR INDUSTRY
Bowl America | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
19 Melville Road | | | |
| 14. FATHER'S NAME First Middle Last
Jesse W. Steinman | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Gladys M. Norris | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
yes WW II | | | | 16b. SOCIAL SECURITY NO.
365 22 4755 | | 17. INFORMANT Address
Rita Steinman, 19 Melville Road, Pasadena | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA Colon
1538
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 Mos. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-16-69 , 19 69 , to 1-27-69 , 19 69 , that (I) (we) lost saw the deceased alive on 1-27-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
C. R. MacDonald | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-28-69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
C. R. MacDonald | | | | | | 22e. ADDRESS
325 Hospital Drive - Glen Burnie | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 31, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Glen Burnie, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
R. L. Singleton | | ADDRESS
Singleton Funeral Home
Glen Burnie, Maryland | | | 25a. REC'D BY REGISTRAR
JAN 30 1969 | | | 25b. REGISTRAR'S SIGNATURE
William J. Judge | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00239 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #5, 6, 7a, b & 8 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|---------|------------------------------|--|--|---|--|---|--------------------|------------------|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| CHARLES | | | STUTSON | | | ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR | | | UNK 19 | | | UNK M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years at birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| male | | negro | | Unknown | | 60 & 70 RS. | | MONTHS DAYS | | HOURS MIN. | | January 5, 1969 3:00 P.M. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Unknown | | | Unknown | | | Unknown | | | Anne Arundel Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Severn | | | | RR 2, Box 220, Jones Road | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Maryland | | | | Anne Arundel | | | | | | | | RR 2, Box 220, Jones Road | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | | partial | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | Werner U. Spitz, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 1/6/69 | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL (CREMATION REMOVAL) (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| | | | | 2-20-69 | | | | C. Ford - Med. School Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | DATE FEB 24 1969 | | | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Anna | | | Ruth Tapp | | | Jan. 7 1969 | | 1504 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| female | | cauc. | | June 28, 1932 | | 36 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Virginia | | USA | | | | Anne Arundel Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Annapolis | | | Anne Arundel General | | | housewife | | own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Anne Arundel | | Annapolis | | YES | | 209 Chinguapin Round Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| William Henry Oaks | | | Della M. Bowling | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | | 214-26-0329 | | Charles H. Tapp - same as #13 above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of breast c gen. metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
174X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/3/1968, to 1/7/1969, that (I) (we) last saw the deceased alive on 1/7/69, 19.69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
S. Borssuck M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
S. BORSSUCK, M.D., | | | | | 22e. ADDRESS
Amos Garrett Blvd., Annapolis, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1/9/69 | | Hillcrest Cemetery | | Annapolis A.A. Md. | | | | |
| 24. FUNERAL DIRECTOR
E. Hopping
Hopping Funeral Home - Annapolis, Md. | | | | | 25a. RECORD BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE
10 1969 | | | |

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Oct 2. 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|-----------|--|--|--------|------|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
A M |
| TA Florence NMN | | | TAYLOR | | | January 25 1969 | | | 9:10 |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | 7. IF UNDER 1 YEAR
MONTHS DAYS |
| Female | Caucasian | | June 21, 1883 | | | 85 | | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH |
| England | | | U.S.A. | | | | | | Anne Arundel |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | | | Anne Arundel General Hospi | | | HOME | | | HOUSEWIFE |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Maryland | | | Anne Arundel | | | Annapolis | | | 13e. STREET AND NUMBER |
| | | | | | | | | | 3 Eastern Avenue |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Isaiah | | | Elizabeth | | | | | | Kay |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| NO | | | - | | | Tom G. Taylor #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral bronchial</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cachexia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerosis, general and cerebral</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
6 weeks
many years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Gangrene L Gt toe, Diabetes mellitus, Rheumatoid arthritis, Hiatal hernia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| Jan 17 '69 | | | Gangrene L Gt toe | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>November 6, 1968</u> , to <u>January 25, 1969</u> , that (I) <u>not</u> last saw the deceased alive on <u>January 24</u> , 19 <u>69</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Charles W. Kinzer | | | January 27, 1969 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Charles W. Kinzer, M. D. | | | 16 Murray Avenue, Annapolis, Md. 21401 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | 1-28-69 | | | CEDAR Bluff | | | Annapolis, Md. |
| 24. FUNERAL DIRECTOR | | | 25a. DATE OF REGISTRATION | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John M. Taylor | | | January 28, 1969 | | | [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00242

CERTIFICATE OF DEATH

00240

| | | | | | | | |
|--|--------------------------------------|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) | | First
JOHN | Middle
CONOVER | Last
TEN EYCK | 2a. DATE OF DEATH
Month Day Year
January 31 1969 | | 2b. HOUR
1:06PM |
| 3. SEX
Male | 4. RACE
Caucasian | | 5. DATE OF BIRTH
27 June 1899 | | 6. AGE (In years
last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Anne Arundel Md. | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
U. S. Navy | | 12b. KIND OF BUSINESS OR
INDUSTRY
Government | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
John Conover Teneyck | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Laura Breckinridge | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
Yes 1920-1940 | | | |
| 16b. SOCIAL SECURITY NO.
120-05-7145 | | 17. INFORMANT
Address
Hendrix NMN Teneyck Fayetteville, New York | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Right Cerebral Infarct and Hemorrhage</u>
4329 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Thrombosis of Right Carotid Artery</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael F. Fornes MD | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-1-69 | |
| 22d. PHYSICIAN'S
NAME (Type)
M. F. FORNES | | | | 22e. ADDRESS
NAVAL HOSPITAL, ANNAPOLIS, MD | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Cremation | | 23b. DATE
2-1-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION (City or Town) (County) (State)
BHADEUSBURG P.G. MD. | |
| 24. FUNERAL DIRECTOR
John M. Saylor & Sons | | | | 25a. REC'D BY REGISTRAR
DATE FEB 5 1969 | | 25b. REGISTRAR'S SIGNATURE
O'Dell | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00243

00241

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---------------------|--|---------------------|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First
Maude | Middle
V. | Last
Thomasson | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> | | 2b. HOUR
2 M |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
5-1-23 | | 6. AGE (In years last birthday)
45 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month Jan. Day 4 Year 1969 |
| 7a. BIRTHPLACE (State or foreign country)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
Anne Arundel | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Anne Arundel | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
North Arundel | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
at home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER
213 Otis Drive | |
| 14. FATHER'S NAME
First Oscar A Middle Phillips Last Phillips | | 15. MOTHER'S MAIDEN NAME
First Flourance J. Middle Thompson Last Thompson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | |
| 16b. SOCIAL SECURITY NO.
42 | | 17. INFORMANT
John B. Thomason | | ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic Heart Disease
398X
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
E. Linhart | | EXAMINER'S NAME (Type)
E. Linhart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
1-4-69
A.A. Co. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-7-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | 23d. LOCATION (City or Town) (County) (State)
Quintland Maryland | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co. | | | | ADDRESS
6517-11 St. S.E. | | 25a. REC'D BY REGISTRAR
JAN 14 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

12300

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1904

FOR THE
YEAR 1904

Thompson

V.

Large

00:00:00

Jan.

12

1

2

Jan. 1904

Jan. 1904

Jan. 1904

Jan. 1904

Jan. 1904

Jan. 1904

Jan. 1904



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--------------------------|--|--|--|--|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 00244 | | | | | | | | | | |
| 00242 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| JOHN | | | RISEON TUCKER | | | JAN 5 1969 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| MALE | | WHITE | | DEC 14, 1900 | | 68 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| ANNAPOLIS | | U.S.A. | | | | ANNE ARUNDEL | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| ANNAPOLIS | | H.A. GEN. HOSPT. | | PIPEFITTER | | U.S. Gov. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD | | AA. CO | | ANNAPOLIS | | | | 106 TUCKER ST. | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| JOHN | | | W. TUCKER | | | ANNIE M. CROSS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | |
| | | | | | | MRS. VIOLET E. TUCKER # 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH CAUSED BY: | | | | | | | | | | |
| 4129 IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> | | | | | | | | 1 HOUR | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>ARTEROSCLEROTIC HEART DISEASE</u> | | | | | | | | 9 YEARS | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1960, to 1/6, 1969, that (we) lost saw the deceased alive on 1-3-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| John M. Taylor | | | | | | 1-6-69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVED (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | JAN 8 1969 | | GLEN HAVEN MEM. | | GLEN BURNIE AAGMD | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| JOHN M. TAYLOR SONS | | ANNAPOLIS MD | | JAN 9 1969 | | John M. Taylor | | | | |

VERIFIED
JAN 15 1969

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 00245 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 00243 | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
MARK | | | | | Middle
CHRISTOPHER | | | | | Last
URICK | | | | | 2a. DATE OF DEATH
JAN Month 15 Day 1969 Year | | | | | 2b. HOUR
7:37 A.M. | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
14 Jan 1969 | | | | | 6. AGE (In years
lost birthday)
YRS. | | | | | IF UNDER 1 YEAR
MONTHS | | | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Anne Arundel Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Ft Geo G. Meade | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
U.S. KIMBROUGH ARMY HOSP | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
None | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
N/A | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | | 13b. COUNTY
Anne Arundel | | | | | 13c. CITY OR TOWN
Hanover | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER
Route #2, Box 161 | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Albert | | | | | Middle
Urlick | | | | | Last
Urlick | | | | | 15. MOTHER'S MAIDEN NAME
First
Patricia | | | | | Middle
Gertrude | | | | | Last
Hartman | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
NO | | | | | (If yes give year or dates of service)
N/A | | | | | 16b. SOCIAL SECURITY NO.
None | | | | | 17. INFORMANT
Address
Albert Urlick, Route #2, Box #161, Hanover, Md | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>
<u>7701</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. }
(b) <u>Albruptio Placenta</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
16 Hrs | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from <u>14 Jan</u> , 19 <u>69</u> , to <u>15 Jan</u> , 19 <u>69</u> , that he (we) last
saw the deceased alive on <u>15 Jan</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the
causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Herbert Spolter</u> | | | | | | | | | | | | | | | DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/>
PHYS. DIRECTOR PHYS. | | | | | | | | | | 22c. DATE SIGNED
15 Jan 69 | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <u>HERBERT SPOLTER, CPT, MC</u> | | | | | | | | | | | | | | | 22e. ADDRESS
<u>US KIMBROUGH ARMY HOSP, FT MEADE, MD</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | | 23b. DATE
JAN 17 '69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL | | | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>ARDEY WITZKE</u> | | | | | ADDRESS
<u>ELIZABETH CITY.</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 16 1969</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Young</u> | | | | | | | | | | | | | | |

54200

RECEIVED

54200

THEY ARE THE ONLY ONE WHO CAN DO IT

THEY ARE THE ONLY ONE WHO CAN DO IT

THEY ARE THE ONLY ONE WHO CAN DO IT

THEY ARE THE ONLY ONE WHO CAN DO IT

THEY ARE THE ONLY ONE WHO CAN DO IT

THEY ARE THE ONLY ONE WHO CAN DO IT

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THEY ARE THE ONLY ONE WHO CAN DO IT

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Handwritten signature or initials

THEY ARE THE ONLY ONE WHO CAN DO IT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|-----------------------------|--|--|--|-------|--|--|--|
| 00246 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 00244 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
William C. Voss | | | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
1 17 69 | | | | | | | | 2b. HOUR
10 A M | | | | | | | |
| 3. SEX
M | | | | 4. RACE
W | | | | 5. DATE OF BIRTH
4-30-13 | | | | 6. AGE (In years last birthday)
55 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. COUNTY OF DEATH
Anne Arundel Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Noeth Hemdel Convalescent Center | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
FURNACE OPERATOR | | | | 12b. KIND OF BUSINESS OR INDUSTRY
KAISER ALUM. | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
BALTO. CO. Md. | | | | 13b. COUNTY
BALTO. | | | | 13c. CITY OR TOWN
ARBUTUS | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
3805 DOOLIDGE AVENUE XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Wilhelm P. Voss | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
anna m. Cogswell | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown
no | | | | (If yes give way or dates of service) | | | | 16b. SOCIAL SECURITY NO.
216 03 3686 | | | | 17. INFORMANT Address Md.
MRS. HELEN M. PAVLICK(daughter) Pasadena | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1929 IMMEDIATE CAUSE (a) Astrocytoma, Grade IV, right temporal
DUE TO, OR AS A CONSEQUENCE OF
(b) Tumor (glioblastoma multiforme) 3 months
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/17/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
R.M. McLaughlin, M.D. DEGREE | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/17/69 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
R.M. McLaughlin, M.D. | | | | | | | | | | | | 22e. ADDRESS
3708 Mountain Rd. Pasadena, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
Jan. 21, 1969 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lo don Park Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland 21122 | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
R. P. Singleton | | | | ADDRESS
Singleton Funeral Home
Glen Burnie, Md. | | | | | | | | 25a. REC'D BY REGISTRAR
JAN 22 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | | | | | | | |

3509 D 1107 1107 X

T XXXXXXXXXXXXXXX . C.T.C

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00247

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|--|----------------------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Robert</i> | | | First Middle Last <i>Warfield</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>1</i> Day <i>5</i> Year <i>1969</i> | | | 2b. HOUR <i>P</i> M | | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>6-18-53</i> | | 6. AGE (In years last birthday) <i>15</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>A.A.Co</i> | | | | |
| 10. CITY OR TOWN OF DEATH <i>Glen Burnie</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel Hosp.</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Student</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>School</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Anne Arundel</i> | | 13c. CITY OR TOWN <i>Severn</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>Box 331-Quarterfield</i> | | | |
| 14. FATHER'S NAME <i>Barnesley</i> | | | | First Middle Last <i>Warfield</i> | | | | 15. MOTHER'S MAIDEN NAME <i>Elizabeth M. Gardner</i> | | | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>Unknown</i> | | | | 17. INFORMANT <i>Ms. Elizabeth Warfield (mother)</i> | | | | ADDRESS <i>Same As #13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Gun Shot-Wound. abdomen</i>
<i>985X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Shortly</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year <i>1-5 1969</i> HOUR A.M. P.M. <i>P.M.</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Gun-Shot-Wound. Abdomen</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | | | 21f. LOCATION Street or R.F.D. No. <i>Quarterfield Road</i> City or Town <i>AA Co</i> County <i>MD</i> State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | | | EXAMINER'S NAME (Type) <i>E. Linhardt</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>A.A.Co.</i> | | | | | |
| 22b. DATE SIGNED <i>1-6-69</i> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 23b. DATE <i>Jan-9, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i> | | | | 23d. LOCATION (City or Town) <i>Glen Burnie, Md.</i> (County) (State) | | | |
| 24. FUNERAL DIRECTOR <i>R.V. Singleton</i> | | | | ADDRESS <i>Bingleton Funeral Home</i> <i>Glen Burnie, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>Jan 8 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

OR AS MEDICAL EXAMINER 1-6-68

00345

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S REPORT

00345

FOR STATE
HEALTH OFFICE

| | | | |
|-------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Death | | Time of Death | |
| Cause of Death | | Manner of Death | |
| Medical History | | Postmortem Examination | |
| Laboratory Examinations | | Remarks | |
| Signature of Examiner | | Signature of Coroner | |
| Date of Report | | Place of Report | |



167cm
154lb
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 8 Film 410 3/10/69 kk | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01926 | | | | | | | | | |
|---|--|--|------------------------------|--|---|--|--|--|------------------------------------|--|--|--------------------------|-----------------|--|--|----------|--|--------|--|---|------|--|--|--|---------|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| Item 13 Film 410 3/5/69 kk | | | | | | | | | | 00248 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First | | | Middle | | | Last | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Lillian | | | | | | Washington | | | 1 Month 17 Day 69 Year | | | | 2 P. M. | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years
last birthday) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | Negro | | | 4-1-16 | | | 52 YRS. | | | | MONTHS | | DAYS | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | USA | | | Separated | | | Anne Arundel Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| Crownsville | | | | | STATE HOSP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission). STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | Anne Arundel | | | | | Crownsville | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | c/o Mrs. Blanche B. Dawson | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | First | | | Middle | | | Last | | | 15. MOTHER'S MAIDEN NAME | | | First | | | Middle | | | Last | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | | | (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Liver, pleural, peritoneal & L.V. metastasis</u>
<u>174X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) <u>carcinoma of the left breast</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 19 <u>68</u> , to <u>1-17</u> , 19 <u>69</u> , that (I) (we) lost
saw the deceased alive on <u>1-17-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) <u>did</u> (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Alberto Gonzalez</u> | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez</u> | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | | 23b. DATE <u>2.24.69</u> | | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace School</u> | | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 28 1969</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | |

01830

OFFICE OF THE SECRETARY OF DEFENSE

1964

01830

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

MEDICAL CERTIFICATION

VR1A75 (4)
30M REV. 7/68

| 00249 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 00246 | |
|---|---|---|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) Arthur R. Watson | | | 2a. DATE OF DEATH
Month 1 Day 6 Year 69 | | 2b. HOUR
6:50 PM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
3-15-99 | | 6. AGE (In years last birthday)
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Michigan | 7b. CITIZEN OF WHAT COUNTRY?
America | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH
Anne Arundel County Md. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
North Arundel Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
 | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
Route 6 Box 20 |
| 14. FATHER'S NAME
First UNK Middle Last | | | 15. MOTHER'S MAIDEN NAME
First UNK Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
 | 17. INFORMANT
Hospital Records Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left ventricular failure
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocarditis lateral
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
days
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pulmonary embolism | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day 19 Year
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 68 , to 1/6 , 19 69 , that (I) (we) last saw the deceased alive on 1/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Max C Frank | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
1/6/69 | |
| 22d. PHYSICIAN'S NAME (Type)
MAX C FRANK MD | | | 22e. ADDRESS
425 SE Ritchie Hwy Glen Burnie Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
8 JAN 1969 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. | | 23d. LOCATION (City or Town) (County) (State)
Glen Burnie AA Md. | |
| 24. FUNERAL DIRECTOR
ITICKLEY FUNERAL HOME Glen Burnie | | | 25a. REC'D BY REGISTRAR
1969 | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

00000

CERTIFICATE OF DEATH

1924

DEPARTMENT OF HEALTH, NEW YORK CITY

1

NAME OF DECEASED
AGE
SEX
RACE
BIRTH DATE
PLACE OF BIRTH
MARRIED
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF RELIGION
SIGNATURE OF CORONER
SIGNATURE OF JURY

DECEASED
AGE
SEX
RACE
BIRTH DATE
PLACE OF BIRTH
MARRIED
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF RELIGION
SIGNATURE OF CORONER
SIGNATURE OF JURY



NEW YORK CITY
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
100 NASSAU ST. NEW YORK 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|---|--|
| 00250 | | CERTIFICATE OF DEATH | | | | | | 00247 | | |
| 1. DECEASED NAME
(Type or print) <i>Charles Mathias Weiger</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year <i>January 11 1969</i> | | | 2b. HOUR
<i>1 A.M.</i> | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>November 4, 1894</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Anne Arundel</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Severna Park, Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>540 Devonshire Ct.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Hosiery Cutter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Hosiery</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Anne Arundel</i> | | 13c. CITY OR TOWN
<i>Severna Park</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>540 Devonshire Court</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>JOSEPH WEIGER</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Catherine Ann Schuetz</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>181-03-1146</i> | | 17. INFORMANT
Address
<i>Mrs. Anna Weiger same</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4339 cerebral thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 months</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>none</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/15/49</i> , 19 <i>49</i> , to <i>1/11/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/11/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>R.M. McLaughlin</i> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/11/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>R.M. McLaughlin</i> | | | | | 22e. ADDRESS
<i>3708 Mountain Rd. Pasadena, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1-13-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Cem.</i> | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
<i>Severna Park F. H. of Robert S. Barranco, Severna Park, Md. 21146</i> | | | | | 25a. REC'D BY REGISTRAR
<i>14 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>William Judge</i> | | | |

00300

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| Item 8 Film 409
2/17/69 kk 00251 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 00248 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) ALICE | | | | | | | | | | | | | | | First Middle Last (WILFONG) WELFONG | | | | | | | | | | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Jan. 23, 1969 | | | | | | | | | | 2b. HOUR 1:15 PM | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH APRIL 17, 1941 | | | | | 6. AGE (In years last birthday) 27 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | 2c. DATE PRONOUNCED DEAD Month Jan. Day 23 , Year 1969 | | | | | | | | | | 2d. HOUR 1:15 PM | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) NEW JERSEY | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Anne Arundel | | | | | | | | | | Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Anne Arundel | | | | | | | | | | 13c. CITY OR TOWN Glen Burnie | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 174 Virginia Apt. J. | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First FRANK Middle H. Last EGGERS | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First MARY Middle L. Last MCDONALD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) unknown | | | | | | | | | | 17. INFORMANT ADDRESS Mr. Orville Wilfong (husband) Same as #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
485x IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED 1/24/69 | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum M.D. | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE January 27/69 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Name Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Jersey City, New Jersey | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR R. Singleton | | | | | | | | | | ADDRESS Singleton Funeral Home Glen Burnie, Maryland | | | | | | | | | | 25a. REC'D BY REGISTRAR JAN 27 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | | | | | | | | | | | | | | | |

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00000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(DATE WHEN)

5.

1941

X

CHIEF OF POLICE, U.S.A.

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

David W. [Signature]

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|-------|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Mattie ^{First} EX ^{Middle} M. ^{Last} Wessler | | | | | | 2a. DATE OF DEATH
Jan. ^{Month} 21 ^{Day} 69 ^{Year} | | | 2b. HOUR
9-30 ^{P.M.} | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7-26-91 | | | 6. AGE (In years last birthday)
77 ^{YRS.} | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Anne Arundel ^{Md.} | | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address)
North Arundel | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Seamstress (Ret.) | | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
711 Mayo Road | | | |
| 14. FATHER'S NAME ^{First} August ^{Middle} H. ^{Last} Rehkop | | | | 15. MOTHER'S MAIDEN NAME ^{First} Minnie ^{Middle} Beasing ^{Last} | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) None | | | 16b. SOCIAL SECURITY NO.
500-10-9231 | | 17. INFORMANT
Mrs. Irene M. Stohrman (daughter) Address #23 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4360 IMMEDIATE CAUSE (a) CVA.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Fracture of Rt radius + symptomatic aortic. | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertension | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Arsenio Santos MD | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1, 22, 69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ARSENIO SANTOS | | | | | | 22e. ADDRESS
325 Hospital Dr. GB Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
1/26/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Blackburn Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Blackburn, Missouri | | | | |
| 24. GENERAL DIRECTOR
[Signature] | | 25a. RECD BY REGISTRAR
Singleton Funeral Home
Glen Burnie, Maryland | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | DATE
JAN 23 1969 | | | | |

10543

RECEIVED

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00253

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00250

| | | | | | | | | | | | |
|--|------------------|--|--|---|---|--|--|---|---|--|---------------------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 1 24 1969 | | | 2b. HOUR
3:30 PM | | |
| CHARLES W. WHEELER | | | | | | | | | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
9-3-1922 | 6. AGE (In years last birthday)
46 47 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
January 24, 1969 | | | 2d. HOUR
3:30 PM |
| 7a. BIRTHPLACE (State or foreign country)
Cambridge Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
AnneArundel Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Laurel | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Hill Ave. Laurel | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
A. A. | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Hill Ave., Laurel | | |
| 14. FATHER'S NAME
Charles W. Wheeler | | | 15. MOTHER'S MAIDEN NAME
Rose Frazier | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes WW 11 | | | 16b. SOCIAL SECURITY NO.
213-14-7422 | | 17. INFORMANT
ADDRESS
Mrs. Wayne Smith Oakley St. Cambridge | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Craniocerebral injuries</u>
968X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR XXXX
1 P.M. 1 24 19 69 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
Subject struck about the head with object | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Hill Ave. Laurel A. A. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED
1/25/69 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/27/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Mem. Park | | | 23d. LOCATION (City or Town) (County) (State)
Cambridge Dorchester Md. | | | | |
| 24. FUNERAL DIRECTOR
Kenneth R. Howard | | | | ADDRESS
Cambridge Md. 21613 | | 25a. REC'D BY REGISTRAR
DATE JAN 29 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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15. *Journal of the American Medical Association*, 273:1225-1226 (1995).

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00254

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00251

| | | | | | | | | | | | |
|--|--|--|--------------------------|--|--|--|--|-----------------|----------|--|-------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Vasseni | | | | | Wilkinson | Jan. Month 8 Day 1969 Year | | | 2:00pm | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | 23 Aug. 1875 | | 93 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Baltimore, Md. | | USA | | | | Anne Arundel | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Annapolis | | Bay Manor Nursing Home | | Housewife | | Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | | | |
| Md. | | | AA | | Severn | Quarterfield Road | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Matthias | | | | | Zoeller | Mary | | | | | Hoppe |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| no | | | | | Mrs. Naomi Care, same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) old Congestive heart failure | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) old Arteriosclerotic Cardiovascular disease | | | | | | | | | | 1 week | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23, 1965, to 12/31/68, 1968, that (I) (we) last saw the deceased alive on 12/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Ray Smith, M.D. | | 10 Jan. 69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Ray Smith, M.D. | | Severna Park, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 11 Jan. 69 | | Mt. Olivet Cemetery | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR. | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Kirkley Funeral Home, Glen Burnie, Md. | | JAN 13 1969 | | Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00231

Jan 8 1950

Washington

General

25 Aug 1949

Wife

Female

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Old man

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00255

CERTIFICATE OF DEATH

00252

| | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|-------------------------------|--|
| 1. DECEASED-NAME
(Type or print) Reese | | | Middle
(none) | | | Lost
WIMBROW | | | 2a. DATE OF DEATH
Month January Day 10 Year 1969 | | | 2b. HOUR P.
3:00 M | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
April 9, 1892 | | | 6. AGE (In years lost birthday)
76 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Anne Arundel | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Anne Arundel Gen. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | | 13c. CITY OR TOWN
Annapolis | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
100 Archwood Ave., | | | |
| 14. FATHER'S NAME First Middle Lost
JOHN M WIMBROW | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
ELIZA I. PARSONS | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
NINA P. WIMBROW | | | Address
#13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
4339
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ARTERIOSCLEROSIS, GENERALIZED
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HOURS
5-YEARS | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PARKINSONISM | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 12-19, 1968 to 1-10, 1969 , that (b) (we) last saw the deceased alive on 1-10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Edward S. Beck | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
1-11-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Edward S. Beck, M.D. | | | | | | 22e. ADDRESS
73 Franklin St., Annapolis, Md. | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
1/14/1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
PARSONS CEM. | | | 23d. LOCATION (City or Town) (County) (State)
SALISBURY MD. | | | | | | |
| 24. FUNERAL DIRECTOR
JOHN M. TAYLOR (Sons) | | | | | | ADDRESS
ANNAPOILIS | | | 25a. REC'D BY REGISTRAR
15 1969 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Russell | | | First Middle Last
(none) WIMPLE | | | 2a. DATE OF DEATH
Month Day Year
January 28 1969 | | | 2b. HOUR P.
5:30 M |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
July 14, 1884 | | | 6. AGE (In years
last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Anne Arundel Md. | | |
| 1d. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Anne Arundel Gen. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt-3, Box 43A, | |
| 14. FATHER'S NAME First Middle Last
Louis Wimple | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sylvia Wimple | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Katie Breashers Address
Annapolis | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
1619 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
2 months
1 year | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Malnutrition due to primary carcinoma of larynx | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSE OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (XXXXXX) attended the deceased from April 12 1966 , to January 28 1969 , that (I) (XX) last
saw the deceased alive on January 28 1969 , and that in (my) (XX) opinion death occurred on the date and hour and from the
causes stated above, (I) (XX) (did) (XXXXXX) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles W. Kinzer | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
January 29, 1969 | | |
| 22d. PHYSICIAN'S
NAME (Type)
Charles W. Kinzer, M.D. | | | | | 22e. ADDRESS
16 Murray Ave., Annapolis, Md. 21401 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
2-1-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Annapolis Neck Annapolis Md. | | | 23d. LOCATION (City or Town) (County) (State) | | |
| 24. FUNERAL DIRECTOR
William Reese | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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661 2 3

00257

CERTIFICATE OF DEATH

00254

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) MARY First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
JAN 31 1969 | | 2b. HOUR
8:15 PM |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
1 Jan. 1886 | | 6. AGE (In years last birthday)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
A.A. Co. Md. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
North Avenue Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
A.A. Co. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
Rt. 3 - Box 447 | |
| 14. FATHER'S NAME
First Middle Last
HARRY (UNKNOWN) | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mignon Klingelhoff | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown no (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO.
217-52-9652 | | 17. INFORMANT
Address
Jeanette Ritterbusch (daughter) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation
2509
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) diabetes mellitus | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years
5 years
5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 10, 1932 to January 31, 1969 , that (I) (we) lost the deceased alive on January 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
R.M. McLaughlin | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/1/69 | |
| 22d. PHYSICIAN'S NAME (Type)
R.M. McLaughlin | | 22e. ADDRESS
3708 Mountain Rd. Pasadena, Md. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
2/3/1969 | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto Maryland | |
| 24. FUNERAL DIRECTOR
Robert Ewing | | ADDRESS
Singleton Funeral Home / Glen Burnie | | 25. REGD BY REGISTRAR
FEB 3 1969 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Mr. E. J. Norton
1015 1st St.
A.M.C.
Glenn County
Markland, A.L.
Honey (H.K.)
212-22nd Street (Ritterbach/Hunter)
Miner Klingel/Hoffen
+ 413-81 447
from date Jan - 1911

Dear Mr. Norton:
I have just received your letter of the 1st inst. and am glad to hear from you.
I am well and hope this finds you the same.
I have not much news to write at present.
I am, very truly,
Your friend,
J. J. Norton

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00255

| | | | | | | | | | | |
|---|-------------------------|---|--|---|--|---|---|-----------------------------------|--|-----------------------|
| 1. DECEASED-NAME
(Type or Print)
First Middle Last
SANDRA JEAN YOUNG | | | 2a. DATE KNOWN OF DEATH
Month Day Year
<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
Jan. 6 1969 | | | 2b. HOUR
M
8 P M | | | | |
| 3. SEX
female | 4. RACE
cauc. | 5. DATE OF BIRTH
April 18, 1961 | 6. AGE (In years last birthday)
8 7 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
8 7 | IF UNDER 24 HRS.
HOURS MIN.
8 7 | 2c. DATE PRONOUNCED DEAD
Month Day Year
1 6 1969 | | | 2d. HOUR
M
8 P M | |
| 7a. BIRTHPLACE (State or foreign country)
North Carolina USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Anne Arundel Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Davidsonville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Patuxent Rd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
student | | 12b. KIND OF BUSINESS OR INDUSTRY
elem. school | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Davidsonville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Gen. Del. | |
| 14. FATHER'S NAME
First Middle Last
Bobby Eugene Young | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Shirley Temple Perry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
no | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
-- | | 17. INFORMANT
ADDRESS
Bobby E. Young - same as #13 above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
814.7
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
1-6 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Slunk & Lunk | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Highway | | 21f. LOCATION Street or R.F.D. No.
R214 | | City or Town
PAAC | | County
PAAC | | State
MD |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
E. Linhardt | | | M.D.
E. Linhardt | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
1-6-69 | | |
| EXAMINER'S NAME (Type)
E. Linhardt | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county)
PAAC | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/10/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Epiphany Episcopal | | 23d. LOCATION (City or Town)
Odenton | | (County)
AA | | (State)
Md. |
| 24. FUNERAL DIRECTOR:
L. Hopping | | | | | 25a. REC'D BY REGISTRAR
JAN 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

00325

REPORT OF PHYSICIAN ON STATE OF MIND AND BODY OF PATIENT

MEDICAL EXAMINATION - CERTIFICATE OF DEATH

100

FOR STATE

HEALTH DEPT.

7

00325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 00259 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 00256 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|---|--|--------------------------------|--|--|-------------------------------|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| Item 6 Film 409 2/10/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH
Month Day Year | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| Joseph | | | | | Zink | | | | | 1 6 69 | | | | | 2:55a M | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | |
| Male | | | White | | | 6/24/03 | | | 68 65 RS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Lithuania | | | USA | | | | | | Anne Arundel Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Crownsville | | | Crownsville State Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Maryland | | | Balto | | | Balto | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | unknown | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Joseph Zink | | | | | Nellie Didwall | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Address | | | | | | | | | | | | | | | | | | | |
| yes Army | | | | | unknown | | | | | Hospital Records, Crownsville State Hospital | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonitis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic brain syndrome</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> , 19 <u>66</u> , to <u>1/6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/6/</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles R. Venter, M.D.</u> | | | | | 22c. DATE SIGNED
1/6/69 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Charles R. Venter, M.D. | | | | | 22e. ADDRESS
Crownsville State Hospital, Maryland | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
1-28-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
U. of Md. School | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
William Reese | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

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1951-10-10

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1951-10-10

1951-10-10